State of Indiana
Statewide Comprehensive Plan
including the
Statewide Coordinated Statement of Need

FY 2006-2007

Prepared for the
Health Resources and Services Administration
by the
Indiana State Department of Health

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LETTER OF CONCURRANCE

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7 December 2005

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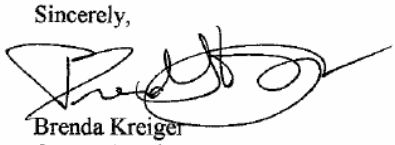
Mr. Carney-

After close collaboration and careful review, the Executive Board of the Comprehensive HIV Services Planning and Advisory Council is pleased to offer our concurrence with the Division of HIV/STD's Statewide Comprehensive Plan for Fiscal Year 2006-2007.

Please let us know if we may be of any further assistance. We look forward to working together with you and the Division in the coming year.

Sincerely,



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INTRODUCTION

Purpose

The Statewide Comprehensive Plan is a thorough description of the HIV service delivery system as it is implemented in Indiana. The plan documents the state's Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Title II funding allocation rationale, its efforts to provide services to those not currently receiving care, its collaborations with other service providers, and its goals and objectives for the maintenance and improvement of the system of care. This year's version of the plan incorporates fully for the first time Indiana's Statewide Coordinated Statement of Need.

Process

In response to the legislative mandates of the Ryan White CARE Act, the Division of HIV/STD at the Indiana State Department of Health (ISDH) regularly revises its HIV service delivery plan based on the changing demands of the epidemic. The current revision was prepared by the Division based on utilization trends and various surveys conducted in FY2005-2006. A working group comprised of Ryan White Titles II, III, and Part F grantees and service providers, persons living with HIV, and other community members reviewed the document in draft form and provided valuable input which was incorporated as appropriate. The final draft subsequently received approval from the Comprehensive HIV Services Planning and Advisory Council for concurrent submission with the FY2006-2007 Title II grant application.

EXECUTIVE SUMMARY

Indiana is primarily a rural state reporting 599 new cases of HIV disease – a reduction of 15% – in 2004. The number of HIV+ persons living in the state, however, continues to increase (by nearly 7.4% last year). The largest increases were seen in men who have sex with men and persons over 40 years of age. Overall, Blacks are more disproportionately affected by the disease than any other demographic group. In a year with decreasing total case reports, women experienced the smallest percentage of reduction and Hispanics actually experienced an increase.

Indiana's various instruments to assess the needs of HIV+ people in the state have yielded results which affirm the importance of the six core service areas defined by the Health Resources and Services Administration. In addition to Primary Medical Care, HIV-related Medications, Oral Health, Case Management, Mental Health Treatment, and Substance Abuse Treatment, the Division of HIV/AIDS has added Transportation and Housing to describe its priority service needs.

Of the 8049 persons living with HIV+, the Division has estimated that 3657 are not currently in care. The current continuum of care is designed to address this population by minimizing barriers and optimizing access to HIV-related medical and social services. The resources of the Ryan White CARE Act grantees and other providers have been coordinated in an attempt to impact each of the priority service needs in an effective and efficient manner. Nevertheless, Indiana has compiled a number of suggestions for service delivery improvement. Many of these are incorporated into its goals and objectives for 2006 and the coming three-year period. Evaluation of the progress towards these goals and of the continuum of care itself will be accomplished through the monitoring efforts of the CARE Act grantees and the Comprehensive HIV Services Planning and Advisory Council.

Part 1 – CURRENT SYSTEM OF CARE

Description of State
Indiana is a mostly rural state with several urban and metropolitan centers; it has an estimated population of 6,159,068 people, based on Census Bureau projections for 2003. The majority of the population is White. The largest minority group is Black, followed relatively closely by persons who identify as Hispanic. The remainder of the population is comprised of Asian-Americans, American Indians and Alaska Natives, and Pacific Islanders.

Epidemiological Profile
Indiana's surveillance data are derived from the HIV and AIDS reports submitted by providers and laboratories to Indiana's Office of Clinical Data and Research (OCDR). Prevalence data do not include those cases known to have moved from the state or to have died. The information that follows is a brief overview of the state's significant epidemiology. A complete epidemiological profile for HIV disease in the state of Indiana (dated June 2005) is available at http://www.in.gov/isdh/programs/hivstd/Epidemiological%20Profile/epi-profiles_index.htm.

Between 1999 and 2002, the reporting of new cases of HIV disease had increased each year. (New cases include both in-state and out-of-state reports submitted to Indiana.) However, in 2003, the number of new cases decreased drastically compared to the preceding year.

At the time, the OCDR proposed that the reduction of new cases was due to the conclusion of the intensified surveillance activities of 2002. The decline, however, has continued through 2004. Given that the total number of tests conducted was relatively consistent between 2002 and 2004, this new trend may indicate that the state's prevention activities are becoming more successful than in previous years.

A slight but interesting difference exists between the rates of decrease for the two types of reports. The number of new cases of HIV showed a significant decline (13%) in 2004. New AIDS case reports also declined but by a slightly larger percentage (17%). This may indicate that disease progression is being delayed modestly, presumably as a result of access to early testing and treatment.

The overall decline in combined tests was 15% from 2003 to 2004. The table below shows the number of new reports received each year, beginning in 1999. The percent of each year's change (% Δ) from the preceding year is also presented in the table.

New Case Reports By Year 1999-2004

New cases by year	HIV		AIDS		Total Disease	
	#	% Δ	#	% Δ	#	% Δ
1999	300	--	309	--	609	--
2000	320	+ 7%	319	+ 3%	639	+ 5%
2001	421	+ 32%	289	- 9%	710	+ 11%
2002	531	+ 26%	372	+ 29%	903	+ 27%
2003	399	- 25%	303	- 19%	702	- 22%
2004	347	- 13%	252	- 17%	599	- 15%

While the general trend in 2004 was a steady reduction in positive test reports, the percentage of change across the race and gender categories continued to vary considerably. In broad terms, over time, non-Whites tend to consistently experience larger increases and the smaller decreases, depending on the direction of the trend. In 2004, reports on Whites declined by 19% compared to 2003, while Blacks declined by only 12%, and Hispanics actually experienced an increase of 4%.

The variance among genders from year to year is much less predictable. In 2004, the OCDR received 16% fewer case reports on men and 9% fewer on women than in the previous year, marking only the second consecutive year of decline for both sexes. The decrease in the number of males is nearly ten percentage points less than in the year prior, but the decrease in females remained nearly in the same. This may be an indication that prevention efforts, while successful in general terms, do not impact equally the behaviors of the individual sexes.

Perhaps the most troubling figures are those for Black women. In a year when every other subcategory showed only a marginal increase or an actual decrease, the number of new cases for Black women increased by more than 2%. Given the relative size of the population in the prevalence data and the fact that this reverses a two-year trend, the Division considers these figures to be significant.

The table below shows total numbers and percentages by race and gender characteristics for new case reports within the last five years. It also calculates the percentage of change by category from one year to the next.

New Case Report Demographics 2000-2004

New cases by race and gender	White	Black	Hispanic	All Other Race Categories	Total		Total Δ
					#	%	
2000							
Male	312	166	26	2	506	79	--
Female	47	77	7	2	133	21	--
Total	359	243	33	4	639	100	--
%	56	38	5	1	100		
Total Δ	--	--	--	--			
2001							
Male	307	177	33	7	524	74	+ 4%
Female	80	95	9	2	186	26	+ 40%
Total	387	272	42	9	710	100	+ 11%
%	55	38	6	1	100		
Total Δ	+ 8%	+ 12%	+ 20%	+ 125%			
2002							
Male	425	253	46	12	736	82	+ 40%
Female	67	87	9	4	167	18	- 10%
Total	492	340	55	16	903	100	+ 27%
%	54	38	6	2	100		
Total Δ	+ 27%	+ 25%	+ 31%	+ 78%			
2003							
Male	302	202	45	3	552	79	- 25%
Female	57	83	7	3	150	21	- 10%
Total	359	285	52	6	702	100	- 22%
%	51	41	7	1	100		
Total Δ	- 27%	- 16%	- 5%	- 63%			
2004							
Male	246	165	48	3	462	77	- 16%
Female	44	85	6	2	137	23	- 9%
Total	290	250	54	5	599	100	- 15%
%	48	42	9	1	100		
Total Δ	- 19%	- 12%	+ 4%	+ 0%			

The number of newborns exposed through vertical transmission from the mother also decreased in 2004. Those definitively diagnosed with HIV infection was lower as well. This continues the downward trend that began in 2001 and can be attributed to better provider and patient education throughout the state. The following table contains comparative information for the past five years. For those newborns whose status has yet to be determined, surveillance activities will continue until a definitive diagnosis can be documented.

Newborn Statistics 2000-2004

Year	Number of Newborns	Infected		Not Infected		Status Unknown At Year-End	
	#	#	%	#	%	#	%
2000	43	4	9	34	79	5	12
2001	54	9	17	21	39	24	44
2002	50	8	16	17	34	25	50
2003	42	6	14	13	31	23	55
2004	39	4	10	14	36	21	54

As of 31 December 2004, a total of 11,344 persons have been reported with HIV disease in Indiana. This number represents the cumulative reports for both HIV and AIDS and includes both living and deceased cases. It is lower compared to the previous year due to the attrition caused by the OCDR's interstate duplication elimination project.

The number of persons living with HIV disease in Indiana increased from 7495 at the end of 2003 to 8049 at the end of 2004. This is an increase of nearly 7.4%. (The increase between 2002 and 2003 was 6.5%.) Of those living in the state in 2004, nearly 53% had progressed to a diagnosis of AIDS. The table below shows the basic demographic qualities of the living cases. The percent of change from the end of the previous report period (30 June 2003) is also displayed. The AIDS prevalence data presented in the table are based on the total number of AIDS diagnoses reported to the OCDR, less those known to have moved from the state or to have died, as of 31 December 2004. Likewise, the HIV prevalence data are derived from reports submitted to the Division's OCDR. These figures exclude those known to have progressed to an AIDS diagnosis, moved from the state, or died. They, too, are accurate as of 31 December 2004. For purposes of HIV services planning, decisions are made primarily on the basis of total living cases of HIV disease (HIV and AIDS reports). This combination provides the most accurate total number of known HIV-infected persons who may potentially require HIV care and services.

Prevalence Demographics through 2004

Prevalence As of 12/31/04	% in pop	HIV			AIDS			Combined		
		#	%	% Δ	#	%	% Δ	#	%	% Δ
Gender										
Male	49	2964	78	- 1	3610	85	+ 0	6574	82	+ 0
Female	51	834	22	+ 1	641	15	+ 0	1475	18	+ 0
Total	100	3798	100		4251	100		8049	100	
Race										
White	86	2198	58	- 1	2588	61	- 2	4786	59	- 2
Black	8	1381	36	+ 0	1389	33	+ 1	2770	34	+ 0
Hispanic	4	184	5	+ 1	252	6	+ 1	436	6	+ 1
Other	2	35	1	+ 0	22	0	+ 0	57	1	+ 1
Total	100	3798	100		4251	100		8049	100	
Age										
0-19	29	46	1	+ 0	31	1	+ 0	77	1	+ 0
20-29	14	443	12	- 1	162	4	+ 0	605	8	+ 0
30-39	15	1249	33	- 4	1104	26	- 4	2353	29	- 5
40-49	15	1428	37	+ 2	1970	46	+ 1	3398	42	+ 2
Over 49	27	632	17	+ 3	984	23	+ 3	1616	20	+ 3
Total	100	3798	100		4251	100		8049	100	
Transmission										
MSM	--	2073	55	+ 4	2657	62	+ 5	4730	59	+ 5
IDU	--	323	9	- 1	483	11	- 1	806	10	- 1
Heterosexual	--	672	17	+ 0	634	15	+ 1	1306	16	+ 0
Perinatal	--	39	1	+ 0	28	1	+ 0	67	1	+ 0
Other/No Risk	--	691	18	- 3	449	11	- 5	1140	14	- 4
Total	--	3798	100		4251	100		8049	100	

The information in the above table shows that the vast majority of living cases of HIV disease (82%) in Indiana are men. The increase in the percentage of women and the decrease in the percentage of men which were seen in 2003

were not seen in 2004. Whites continued to be the most infected racial group; but compared to their presence in the population at large, Blacks were still the most disproportionately affected. The percentage of Blacks reported with an AIDS diagnosis increased by 1% while that for Whites decreased by 2%.

The largest risk group continued to be composed of men who have sex with men (MSM); this is the only risk category to see an increase (by 5 percentage points) in the report period. The disease concentration in the 30-39 age bracket continued to dissipate while the 40-49 and the 50-plus brackets experienced a steady growth. For male youth, the greatest risk of exposure was homosexual contact; for women of all ages, it was heterosexual contact. Infection due to the use of injection drugs (IDU) continued decreasing among all groups. Overall, Indiana's HIV disease patterns were similar to those of the surrounding states.

Current Trends
The epidemiological data illustrate three important trends to consider when planning future HIV services programming.

1. Women.
   This population experienced the least significant percentage of decrease in new case reports by gender between 2003 and 2004 (9% compared to 16% for men).

2. Blacks.
   This population, regardless of gender, is the most disproportionately represented in the data. Blacks account for 36% of the living cases of HIV and 33% of the living cases of AIDS; however, they comprise only 8% of the general population.

3. Hispanics.
   This population experienced the only percentage increase in new case reports by race between 2003 and 2004 (4% compared to a decrease of 19% and 12% for Whites and Blacks, respectively).

Expected Trends
In addition to anticipating that the current trends will continue, OCDR expects that with the availability of effective treatments the rate of death will maintain its downward trend. Coupled by new reports, this will result in an overall prevalence increase, and the trends among subpopulations indicate that Black women and (to a somewhat lesser extent) Hispanic men will be will be most adversely affected.

Brief History of Service Response to HIV in Indiana
The first specific reference to AIDS in the Indiana State Code appeared in 1986 when the state required physicians and hospitals to report confirmed cases of AIDS to ISDH. The state's first service component was the HIV Care Coordination Program which was the end result of recommendations made by the HIV/AIDS Health and Human Services Planning Project for Indiana conducted during 1989 and 1990. It was determined in the planning process that "care coordination services are the foundation upon which all other HIV/AIDS health and human service programs are built." The plan identified the need for regional care coordination on a statewide basis, site communication, and the standardization of data collection and intake procedures. By the early 1990's two sites were well established as services providers, the AIDS Task Force in Fort Wayne and the Damien Center in Indianapolis. As the plan for provision of statewide services evolved, pilot projects in Evansville and Gary were established and overseen by the Damien Center. The projects were funded through a small grant from Indiana's Family and Social Services Administration (FSSA).

By 1991, the Division was receiving Ryan White CARE Act dollars. The award was used to implement traditional AIDS Drug Assistance and Early Intervention Plans (ADAP and EIP, respectively) through a sub-contractor. From the beginning, these services were available statewide.

In 1992, Indiana received its first Title III award. This was the first HIV-specific funding that was allocated for a particular metropolitan area (in this case, Marion County). The project provided access to medical services and some case management activities for those living within its geographical area. Additional Title III programs were funded over the years, both for planning projects and for service delivery.

In December of 1992, FSSA transferred the administration of the HIV Care Coordination Program to the Division which then became responsible for issues concerning funding, policy setting, and program administration. By 1993, the number of care sites had increased to twelve. Since that time, clinic-based medical case management programs

have been developed at Wishard and Methodist Hospitals in Indianapolis, and several sites have expanded to include Spanish-language and substance abuse specialists.

Funds for housing and emergency assistance were first received in 1993 and administered by a sister agency of the ADAP sub-contractor. (These two agencies eventually merged.) Like ADAP and EIP, these services were immediately available around the state through the network of HIV Care Coordination sites.

By the end of the decade, administration of the housing program was transitioned to the Indiana Housing and Community Development Authority, and the Division also ended its relationship with the sub-contractor. As all medical services were brought in-house at ISDH, the program shifted from its focus on ADAP and developed a new insurance-based service. Leveraging premium payments made to the state's high-risk insurance pool, the Division doubled the number of its enrollees in less than a year and was able to offer comprehensive medical coverage rather than only the traditional ADAP and EIP services.

Currently, Indiana boasts two Title III clinics, a strong partnership with the neighboring Title III clinic in Northwest Kentucky, a free statewide insurance-based HIV Medical Services Program, a statewide HIV housing program, an HIV substance abuse support program, a growing "emerging communities" project, a Minority AIDS Initiative designed to increase minority participation in services, and a regional Midwest AIDS Training and Education Center.

Statewide Coordinated Statement of Need

Periodically, the Division develops an updated edition of its Statewide Coordinated Statement of Need (SCSN). The SCSN is a general statement of the needs of persons living with HIV in the state of Indiana. It seeks to describe the epidemiological trends, barriers to care, and service gaps for the affected population. This year, the SCSN is being fully incorporated herein and will not exist as a separate document.

Data sources

In addition to updated epidemiological information from the OCDR, the Division referenced six primary sources of data in the preparation of this version of its Statement of Need.

1. State Needs Assessment Report

   For some time, the primary source of information used to create the Statewide Coordinated Statement of Need has been the state's official HIV/AIDS Needs Assessment Report, which was prepared in February 2002 by the Partnership for Community Health, Inc., a consulting agency based in New York. The complete needs assessment contained three separate reports. The first was an epidemiological report which provided a profile of potential service recipients. The second report described the findings of the actual needs assessment and presented the quantitative and qualitative information obtained through surveys and focus groups with 404 HIV+ persons from various sub-populations including African Americans, Hispanics, heterosexual men and women, and injection drug users. This assessment report addressed absolute service needs, perceived needs or demands, fulfilled needs, absolute unmet needs, unmet perceived needs, and barriers to care as identified by HIV+ persons. The third report incorporated information gathered from service providers in order to estimate the capacity of the system and any related gaps.

   Four different data collection methods were used by the Partnership for Community Health for this project.

   a. A review of secondary information (including epidemiological and service utilization data provided by ISDH) was performed to estimate the HIV and AIDS incidence and prevalence rates, the sampling frame, the number of service units provided by the care system, and the general health status of HIV+ persons in Indiana.
   b. A survey was conducted among a representative sample of HIV+ persons, many of whom were identified as out-of-care or belonging to difficult to reach populations. The survey provided updated demographic estimates, as well as information on co-morbidities, service awareness levels, and adherence rates. It also gathered data related to the perceived knowledge, demand, utilization, and barriers related to particular services.
   c. Sixteen focus groups were conducted among target populations, along with key informant interviews. These sessions provided an in-depth view of the needs and barriers to services and helped to validate findings from the survey.
   d. A provider information form was circulated to collect information on the services provided, funding for services, number of clients served, unduplicated client counts, and providers' perceptions of service barriers.

2. Consumer Satisfaction Survey Results

   The Division conducted a satisfaction survey of its HIV Care Coordination and HIV Medical Services Program clients in the spring of 2003. The responses were submitted to sociologists Carrie E. Foote-Ardah, Ph.D., and Eric R. Wright, Ph.D., at Indiana University – Purdue University at Indianapolis for analysis. The resulting report was reviewed by the Division and circulated to the advisory council.

   The survey included a battery of questions developed to measure client satisfaction with each program. Part A of the questionnaire pertained to case management services, Part B to medical services. Satisfaction was measured using a five point Likert scale in response to positive statements about the programs such that agreement corresponded with satisfaction. Additional questions gathered the client's gender, race, current program enrollment status, length of enrollment, and place of service. A total of 726 questionnaires were returned and analyzed.

3. Women and Families Needs Assessment Results

   The "Indiana HIV/AIDS Women, Children and Families Needs Assessment Study" was conducted with HIV+ women and HIV Care Coordination staff from around the state. Dr. Carrie E. Foote-Ardah, working in conjunction with the Family AIDS Network, initiated a statewide exploratory assessment of the needs of women, children, and families impacted by HIV. The study documented the HIV-related needs of women and children in the state of Indiana with specific attention to the nature and quality of available supportive and care resources (e.g., housing, case management, medical care, legal services, child and family services, transportation, mental health, substance abuse, support groups), the experiences and satisfaction with services used, the barriers to supportive services and care resources, and the changes needed to improve existing services and the lives of women and children impacted by HIV.

   The study consisted of three phases. Phase one consisted of administering a small survey to 125 staff members from the HIV Care Coordination sites across Indiana. Staff included program managers, HIV Care Coordinators, prevention specialists and substance abuse counselors. Data were collected from 90 of these staff members regarding the services offered to women and children at their respective agencies (if any), the perceived service needs of women, any perceived barriers to accessing available services, and possible solutions to existing gaps in services.

   Phase two consisted of three focus groups conducted with a smaller sample (32) of the HIV Care Coordination staff in three different parts of the state: north, central and south (representing 12 care sites). Although groups were not representative of the entire staff population, they were very diverse with regard to key demographics. Through the focus groups, more in-depth data on women and children service needs and barriers were collected emphasizing HIV Care Coordination experiences.

   Phase three consisted of seven focus groups (involving 60 total participants) and in-depth interviews with two additional HIV-infected women. Of the participants in this phase, 51% were Black, 43% were White, and 6% were Hispanic or "Other" races. Nearly all had a least one child (88%), and 76% were currently taking HIV medications. Separate focus groups were completed in different parts of Indiana (two in central and one each in east central, northeast, northwest, southeast, and southwest Indiana). Data gathered paralleled that collected from care site staff but emphasized female consumer experiences.

4. State Needs Assessment Update 2004

   In the spring and summer of 2004, the Division endeavored to update its 2002 Needs Assessment Report. The Division distributed 466 client surveys to its 15 HIV Care Coordination sites. The surveys asked clients if certain medical and social services where currently needed, available, and being received on a regular basis. Basic demographics were also collected for each respondent.

   The Division received 444 completed surveys in response. Males composed 74% of the respondents, females composed 25%, and 1% identified as transgendered. The racial composition of the respondents was Black (35%), White (55%) Hispanic (7%), and Other (3%). Marion County was the best represented county among respondents (37%), followed by Lake (9%), Allen (9%), St. Joseph (9%) and Vanderburgh (5%). All other counties had a response rate of less than 5%.

The design of the questionnaire allowed for the analysis of the degree to which a particular service was needed but not currently available. This discrepancy between need and availability (i.e., the "unmet need") was considered to be of primary importance.

In terms of overall unmet needs, respondents from smaller counties tended to report more needs that were not being met currently. These counties included Lawrence, Owen, Hamilton, Spencer, and Jay. Respondents from larger counties (such as Marion, Lake, and Allen) tended to report fewer unmet needs.

5. Emergency Financial Assistance Project Report
In October 2004, the Division launched a short-term emergency financial assistance project throughout Indiana. The Division allocated $600,000 in unobligated Title II funds to the project and used its network of standard HIV Care Coordination sites and a third party payer to implement it. Requests for assistance were coded as either "Agency-Direct" or "Client-Direct." The former were requests for reimbursement of bulk-quantity purchases of items to be distributed by the agency to needy clients. The latter were requests for reimbursement of payments made by the agency on behalf of a particular client. The care sites submitted a total of 1176 unduplicated requests between October 2004 and March 2005.

The raw number of requests was distributed among the regions thusly: Northern (36%), Central (21%), and Southern (43%). The actual expenditure distribution, however, was slightly different – Northern (33%), Central (11%) and Southern (57%). For the "Client-Direct" requests, 22% were submitted for female clients and 24% for non-white clients. These percentages are slightly less than those of the HIV Care Coordination population which is 24% and 41% for females and non-Whites, respectively.

Analyzing expenditures by geographic region, the largest percentages were spent on men in the Southern region (65%) and on women in the North (58%). The expenditures for Blacks and "Other" races were greatest in the North (58% and 91%) and for Whites and Hispanics in the South (66% and 60%).

6. State Needs Assessment Update 2005
In an effort to confirm the continued relevance of data from earlier assessments, the Division conducted a larger-scale survey of its HIV Care Coordination clients in June 2005. The survey was mailed to 1715 individuals and consisted of 22 questions presented in both English and Spanish. Of the 550 responses, 544 were in English. The main portion of the survey asked a series of questions about the period of time during which clients experienced a particular hardship (e.g., the number of days in the last month the client was hungry or unable to get food).

While each of the state's HIV Care Coordination regions was represented, the majority of responses were received from the Indianapolis, Gary, and Fort Wayne areas. Most respondents were male (80%) and White (71%). Nineteen percent of the respondents were Black, and 6% were Hispanic. Most respondents (84%) had been receiving HIV Care Coordination services for more than 12 months, and over half (59%) reported an annual income of less than $12,000.

Priority service needs

The Division recognizes the core services established by the Health Resources and Services Administration (HRSA): Primary Medical Care, HIV-related Medications, Oral Health, Case Management, Mental Health Treatment, and Substance Abuse Treatment. The Division also notes the importance of Transportation and Housing services. In the past, these areas had been collected under the heading of Supportive Services. This year, they are being listed separately in addition to the core services. The paragraphs which follow describe Indiana's specific rationale for each category's inclusion as a priority service need.

1. Primary Medical Care
In the 2002 Needs Assessment Report, more than half (53%) of the HIV+ respondents indicated that primary medical care was the service most necessary to ensuring good health. Regardless of gender or race, respondents consistently ranked medical care as their top need. Even in the absence of severe symptoms, access to treatment, particularly primary medical care, was widely recognized by respondents as absolutely necessary to maintain and improve the health of HIV+ individuals.

In the Division's satisfaction survey, clients were asked about their experiences in the HIV Medical Services Program. More than two-thirds of these respondents indicated program satisfaction across all items. Among the areas with the highest ratings were: the program's success with helping clients to

access medications (84%) and medical care (81%). Though these high levels of satisfaction highlight the importance of the HIV Medical Services Program, some clients (27%) disagreed with the statement that the program covers all of their medical needs. Therefore, in addition to access, securing comprehensive medical coverage is also considered a need in Indiana.

The Needs Assessment Update conducted in 2005 confirmed that access to basic medical care remains one of the most critical needs of HIV+ persons. Respondents ranked this area second only to pharmaceuticals. The results of the recent Emergency Financial Assistance Project point to the same conclusion. Nearly one-third of the available $600,000 was used to reimburse physicians, hospitals, and laboratories for HIV-related services that had been rendered.

2. HIV-related Medication
   In the 2002 Needs Assessment report, 12% of the HIV+ respondents ranked drug cost reimbursements among their most important needs. Though this figure is lower than expected, the development and utilization of new antiretroviral agents has been central to the treatment of HIV disease and has increased the life expectancy of infected persons. The documented positive health outcomes arising from the use of these innovative medications have confirmed the continued need for HIV medication assistance. This need for pharmaceuticals is substantiated by other findings within the Needs Assessment Report. According to the report, 54% of the HIV+ population in Indiana exhibit symptoms that would indicate the need for antiviral treatment (based on the criteria established in the Public Health Services treatment guidelines).

   Again, the Needs Assessment Update of 2005 confirms the importance of access to pharmaceuticals. The majority (more than 40%) of the survey respondents ranked this area as their primary area of need.

3. Oral Health
   Nearly a quarter (24%) of the respondents in the Needs Assessment of 2002 indicated that dental care was the service most necessary to ensuring good health. The report also revealed that dental care is the greatest unmet service need in Indiana. Of all respondents, 65% indicated some level of need for dental services, but only 52% acknowledged that they had received the necessary care. In general, dental care was ranked as the third most important service for HIV+ persons.

   Not surprisingly, the 2004 and 2005 Update surveys confirmed this ranking as well, though only 10% of the respondents to the 2005 survey indicated experiencing any trouble obtaining dental care services. Nevertheless, the Emergency Financial Assistance Project results are evidence that Oral Health (or the ability to pay for it) remains a serious concern; nearly 24% of the available funds were used to reimburse dental providers for services rendered.

4. Case Management
   In the Needs Assessment Report of 2002, one-fifth (20%) of respondents indicated that case management was the single service most necessary to ensuring good health. The need for case management services was ranked just slightly lower than dental services. Case management plays a central role in increasing access to medical and social supportive services and in decreasing the fragmentation of care.

   Based on the Division's satisfaction survey results, clients appear very satisfied with their case managers. Across a number of indicators, clients report strikingly high levels of satisfaction with most dimensions of the program. A small minority of clients, however, was somewhat less satisfied with the HIV Medical Service Program than with HIV Care Coordination; the analysis found no significant effect of case management on satisfaction with the medical program. In terms of overall HIV Care Coordination experience, only twelve respondents (less than 7%) reported having a bad experience. Those expressing dissatisfaction were most likely to express concern with accessibility issues (e.g., case manager availability and response time to client concerns).

   Case management was again ranked as one of the top five necessary services in the 2005 Needs Assessment Update survey. Most respondents (84%) indicated satisfaction with the competency of their case managers.

5. Mental Health Treatment
   Mental health treatment did not rank as a priority concern in the 2002 Needs Assessment, neither has it been exhaustively addressed by the Division to date. As part of the 2005 surveys, after respondents chose their top "critical" need, they were asked to indicate which of five additional services was most important to them. Mental Health Treatment received the third largest number of responses (more than 15%).

6. Substance Abuse Treatment
   Like mental health services, substance abuse treatment did not rank as a major concern on the 2002 Needs Assessment. By 2005, little had changed. Of the five secondary services from which to choose on the 2005 survey, respondents chose Substance Abuse Treatment least often (less than 7%). Given the anecdotal evidence available through case management program audits, this percentage is surprisingly low, though it is accepted that the issue will be drastically under-reported – even in anonymous settings – due in part to its illicit nature.

7. Transportation
   In the Needs Assessment Report of 2002, nearly one quarter (24%) of the respondents indicated that transportation was the service most necessary to ensuring good health. While access to this type of service is regarded as essential to quality of life, consumers consistently report that they are unable to obtain the service on a regular basis. The inability to find affordable, reliable methods of transportation is often cited as a reason for failure to access services that are otherwise available.

   A substantial portion of the Emergency Financial Assistance Project funds (nearly 5%) were used to address transportation-related needs in 2005. The Needs Assessment Update of the same year indicated that a significant proportion of the respondents missed work or were unable to obtain their medications (22% each) due to the unavailability of adequate transportation.

8. Housing
   Consumers often require housing (and utility) assistance in order to maintain an adequate standard of living. Housing assistance in Indiana is generally confined to short- or long-term rental assistance. Those without access to assistance of this kind are often in jeopardy of hunger and homelessness. In 2003, AIDS Housing of Washington drafted the Indiana HIV/AIDS Housing Plan for the Indiana Housing and Community Development Authority, the City of Indianapolis, and the Damien Center. The plan identified affordability as the primary barrier to accessing housing for HIV+ people in Indiana. In every region of the state, it is extremely difficult to find safe and sanitary housing that is affordable for low-income individuals.

   The preliminary analysis of the Women and Families Needs Assessment data reveals that the presence of children in the household intensifies the need for housing assistance and brings with it the additional need for child care. Nearly all care site staff (89%) reported child care as a significant need for their clients, yet 43% of staff indicated that this service was not available. In general, child care was ranked as the fourth most important auxiliary service need (after case management, mental health care, and housing) for women.

   The results from the Needs Assessment Updates of 2004 and 2005 indicated that shelter-related issues continue to impact HIV+ individuals significantly. In the secondary "additional concerns" tier of the 2005 survey, 30% of the respondents chose housing as the area most important to them. Likewise, the Emergency Financial Assistance Project spent nearly 13% of its funds to reimburse shelter-related providers.

Unmet need estimate

In 2003, the Division calculated the approximate number of persons who are aware of their HIV+ status but are not actively engaged in care. Using testing data from the OCDR to determine the total size of the population of persons living in Indiana with HIV, the Division then deducted any individual with a CD4 or viral load laboratory report on record since 1 January 2003. The resulting list contained 4726 names. Using additional sources of information to indicate involvement in care, this estimate was updated to 4246 persons in 2004.

In late 2005, taking into consideration updated information from key sources, as well as the feedback received from HRSA following the submission of the original estimate, the Division revised its unmet need framework for FY2006-2007. At HRSA's request, the Division has attempted to differentiate between those with HIV and those with an AIDS diagnosis when calculating the final estimate. This distinction, however, has no bearing on the Division's service delivery system.

Again, the Division began with the state's prevalence total. As of 31 March 2005, OCDR had 3798 surveillance records for individuals living with HIV and 4251 records for those living with AIDS. From these, any record which also had corresponding CD4 or viral load reports dated between 1 April 2004 and 31 March 2005 was subtracted. There were 4197 such reports.

As with the FY2005-2006 estimate, Medicaid information from the same time period was then solicited from OMPP. For the first time, the data provided was sufficient to determine patient utilization of anti-retroviral therapy pharmaceuticals. The Medicaid data contained 1335 applicable records; of those, 186 matched records in the remaining prevalence data and were eliminated from it.

Finally, utilization data from the Division's HIV Medical Services Program was reviewed. For the timeframe of 1 April 2004 through 31 March 2005, AIDS Drug Assistance Plan (ADAP) data showed that 158 individuals had received anti-retroviral therapy. Insurance utilization data did not contain this level of detail and, therefore, was not used in this estimate. Of the 158 ADAP records, 9 matched with and were eliminated from the balance of prevalence records. The remaining records comprise the state's unmet need population. For FY2006-2007, this population is estimated to consist of 2028 individuals with HIV and 1629 with AIDS. The table below shows the relevant details for Indiana's official estimate of unmet need for FY2006-2007.

Unmet Need Framework for FY2006-2007

Unmet Need Estimate	Prevalence Population		Indicators of Care								Estimate	
	HIV	AIDS	-	CD4/ Viral Load	-	Medicaid	-	HIV Medical	=		HIV	AIDS
Value	3798	4251	-	4197	-	186	-	9	=		2028	1629
Percentage	47	53									55	45
Source	OCDR			OCDR		OMPP		Services				

These estimates are assumed to be the state's population of HIV+ people with knowledge of their status but without access to or need for medical care. The Division acknowledges that this estimate has certain limitations as it disregards the possibility of private insurance or Veterans Administration coverage, though the comparison with CD4 and viral load testing information likely captured the majority of individuals in those categories. It also does not consider individuals who do have access to care (e.g., the entire HIV Medical Services population) if CD4 counts, viral load counts, or specific drugs have not been obtained within the reporting period. Further, by design, it does not define those who are receiving non-HIV medical services or drugs as "in care."

Demographic Details of Unmet Need Population for FY2006-2007

Race	Male		Female		Total	
	#	%	#	%	#	%
White	1759	48	277	8	2036	56
Black	1018	28	339	9	1357	37
Hispanic	208	5	27	1	235	6
Other	23	1	6	0	29	1
Total	3008	82	649	18	3657	100

The table above describes the demographic qualities of the current population with "unmet need." Initial analysis shows that the demographics of the unmet need group closely resemble those of the entire prevalence group with 82% males, 56% White, 37% Black, and 73% aged between 30 and 49 years. This appears to indicate that particular subpopulations are not impacted disproportionately by access-to-care issues; therefore the results of this exercise did not significantly impact the design of the service delivery system or the resources allocated to provide services.

Gaps in care

However, based on the substantial size of the estimated "unmet need" population, the Division recognizes that one of the primary gaps in care is the inability to consistently engage and maintain HIV+ persons in care. To address this issue, the Division conducts a number of activities to identify HIV+ individuals who are not actively seeking care.

Currently, the state-funded HIV Care Coordination Program oversees 15 agencies that work closely with service providers across the state to coordinate medical care, health insurance for the uninsured, and social services. Many out-of-care consumers are brought back into care through referrals into this network. In Marion County specifically, the Title II-funded HIV Support Center has been highly effective in its efforts to capture consumers who have been "lost to care," bringing them back into the system to receive necessary social and medical services.

Divisional procedure states that, for persons who test HIV+ but do not return for their test results, a Disease Intervention Specialist will be dispatched by the OCDR to deliver the test results in person and to provide information about available services. New specialists receive training regarding the availability of HIV Care Coordination services throughout the state and are trained to provide this information to HIV+ persons that they encounter. The relationship between the Division's services programs, the HIV Care Coordination agencies, the CTS sites, and the Disease Intervention system are under continuous review to ensure that the programs are operating synergistically with the common goal of engaging and maintaining persons with HIV in care.

To strengthen its ability to retain consumers in care, the Division established a requirement for all HIV Medical Services Program recipients to engage and remain in the state's HIV Care Coordination Program. This is very similar to the requirement of Indiana's Housing Opportunities for Persons With AIDS program. All new applications must originate from the sanctioned care sites where quality control measures can be implemented, if necessary. This requirement became effective on 1 January 2004.

In addition to the issues surrounding the task of engaging and maintaining people in care, the Division recognizes a number of other serious gaps in care. These can be roughly correlated to each of the priority service needs and impact both those considered to be in and out of care according to the HRSA definition.

1. Primary Medical Care
   The ability to afford primary medical care continues to affect the rate at which HIV+ persons access such care. The Division's HIV Medical Services Program provides essentially free access to medical care; however, due to limited federal funding, the program is currently in the process of establishing a waiting list. Other programs – such as the state's Title III clinics and Wishard Hospital's Advantage Program – exist with similar funding restrictions and are unable to serve every applicant. Strict eligibility criteria also affect how easily a person can access this type of care. "Access-on-demand" is not a reality in Indiana.

2. HIV-related Medication
   As with primary medical care, the high cost of medications continues to prevent many individuals from accessing the necessary pharmaceuticals. Again, enrollment caps, funding restrictions, and narrow eligibility guidelines often prevent immediate access.

3. Oral Health
   Dental care is only covered by the HIV Medical Services Program during the first three months while the enrollee is in the pre-existing condition period for insurance. Services offered through Wishard Advantage and the Title III clinics are longer-lasting but provide only the most basic services; high-priced services such as extractions are often not covered. And again, the enrollment caps, funding shortages, and eligibility guidelines impact this service as well.

4. Case Management
   The Division's HIV Care Coordination is available to all HIV+ residents at no cost through 15 care sites throughout the state. The program continues to expand each year despite decreasing funding. In 2005, the program experienced a 5% overall funding cut and was forced to shift the cost of its quality assurance measures to the state's Ryan White Title II award in order to adequately fund the case management positions in the field. While no one has been declined HIV Care Coordination services to

date, continued funding reductions will ultimately impede the Division's ability to provide this service without restrictions.

5. Mental Health Treatment
   Access to affordable mental health treatment is fairly limited in Indiana for those with low incomes or without insurance. During the pre-existing condition period, the HIV Medical Services Program covers only the cost of a small number of anti-depressant and anti-anxiety drugs. Once this period has expired and full insurance benefits are available, the enrollee is covered for only 20 out-patient visits for mental health and substance use issues combined. In-patient visits are limited to a combined 180 days for major medical, mental health, and substance abuse treatment. Title III benefits are generally even more limited. All programs are impacted by the enrollment caps, funding shortages, and eligibility guidelines that restrict most services in the state.

6. Substance Abuse Treatment
   The availability of substance abuse treatment is limited in same manner as mental health services, as the two are consistently combined into a single benefit. However, assistance with preparatory counseling is somewhat more readily available. The Division funds eight agencies across the state to provide intensive supportive care services designed to prepare the consumer for entry into treatment. Often, as affordable treatment options fail to appear, the support specialist will act as the pro tem treatment professional, working to encourage harm-reduction strategies, HIV medication adherence, and engagement with other care systems.

7. Transportation
   With the exception of the limited transportation assistance provided to those with Indiana Medicaid, reliable and affordable transport services are nearly non-existent in Indiana. One project, the HIV Support Center (known locally as Channels of Hope), does provide transportation for eligible individuals referred from the local HIV Care Coordination programs, testing centers, and clinics. This service is provided free of charge, but the individual must be considered at high risk for disengaging from care. Those with issues of homelessness, mental health, or substance abuse receive priority. Because it is contingent upon the EC formula allocation within the Title II grant, funding for this project is inconsistent from year to year.

8. Housing
   The majority of housing services for HIV+ individuals in Indiana are provided by the Indiana Housing and Community Development Authority through the Housing Opportunities for People With AIDS (HOPWA) program. (In Indianapolis, HOPWA is coordinated by the City of Indianapolis.) Sub-grants are awarded to the local HIV Care Coordination agencies to distribute to its clients determined to be most in need. Strict eligibility criteria apply, and the client remains responsible for a portion of the housing cost. Currently, nearly every region is maintaining a waiting list for this important form of assistance.

Prevention needs

ISDH administers 29 grant-funded projects through its HIV Prevention Program. These projects provide an assortment of prevention interventions, including Group Level Interventions, Partner Counseling and Referral Services, Health Communications and Public Information, Outreach, Prevention Case Management, and traditional Counseling, Testing and Referral Services. The program serves 50 of the 92 counties in Indiana. Many of the funded agencies are using Diffused Effective Behavioral Interventions (DEBI's) in accordance with recommendations from the Centers for Disease Control and Prevention.

The HIV Prevention Program collaborates regularly with other programs within the Division to improve service provision. The program's Prevention Case Management initiative works especially closely with the Hepatitis Program to provide services to extremely high-risk individuals diagnosed with Acute Hepatitis C through a pilot study. The Prevention Case Management initiative is also a standard referral used frequently by the HIV Care Coordinators for clients who have been assessed as having an exceptional potential for continued high-risk sexual behavior.

In 2005, the HIV Prevention Program successfully provided "HIV 101" and testing training in Spanish in an effort to address the rapid growth of the Hispanic population in Indiana. From this collaboration, a number of service needs were identified, most of which related to inadequate funding. The program requires

additional funds to provide services in Spanish uniformly throughout the state. It also lacks sufficient funds to support Prevention Case Management services, DEBI interventions, and new projects (such as Prevention with Positives and Prevention into Care) in a robust manner.

Current Continuum of Care

The Division maintains that a robust service continuum begins with a commitment to providing free, comprehensive case management services for people testing positive for HIV. The HIV Care Coordination Program, supported largely through state appropriations, is considered to be the "backbone" of the service delivery system and serves as the gateway to every other major HIV-related service in the state. The Division is similarly committed to providing no-cost medical services and pharmaceuticals to the maximum number of eligible individuals who can be supported with existing funding. With regard to the Title II funds from the Ryan White CARE Act, the provision of comprehensive medical services is considered to be the Division's first priority. This funding, therefore, is largely dedicated to the operation of the Division's two primary HIV health care projects: the HIV Medical Services Program and the Emerging Communities Initiative. These programs, along with others that address the state's priority service needs, are described in the sections that follow.

1. Primary Medical Care

   The Division of HIV/STD provides access to medical care primarily through its HIV Medical Services Program. This program has two main medical care components: EIP and the Health Insurance Assistance Plan (HIAP). EIP provides immediate access to a limited array of HIV-related health care procedures. EIP benefits expire after approximately three months, at which time the HIAP benefits become effective for the coverage of overall health care. More comprehensive than EIP, HIAP ensures access to full coverage medical care. The program leverages its funding by purchasing insurance for enrollees through the state's high-risk insurance pool, Indiana Comprehensive Health Insurance Association (ICHIA)**.** HIAP pays for the premium and other expenses associated with the ICHIA policies. These plans are available to Indiana residents who are HIV+, earn less than 300% of the federal poverty level, are otherwise uninsured, and under the age of 65. The Division allotted more than $10 million to maintain its medical services in FY2006-2007.

   Additional access to primary medical care is provided through the Emerging Communities Initiative which also has two main two components: free clinical services and a unique HIV Support Center project. Both components are limited to the Marion County region. A recipient of these services must qualify as a member of the Emerging Communities target group; in Indiana, the target group consists of HIV+ minorities at risk of substance abuse, homelessness, or mental illness. The free clinical services are made available through two local hospital-based projects (the LifeCare Program of Clarian Health and Wishard Health Services) and are designed to supplement existing health care services in the Indianapolis area. These clinics provide access to quality early interventions, out-patient medical care, and necessary laboratory services as a stop-gap measure until the consumer can be transitioned into more comprehensive programs. The HIV Support Center is a specialized "safety net" project, created to provide intensive support services to keep the consumer in care. It works to ensure that consumers appear for appointments and follow the prescribed care plans for maximum positive health outcomes. Support center staff members also regularly integrate secondary prevention messages into their contacts with consumers.

   The Marion County Health Department supports four similar projects through its Title III program. Primary health care services are offered through Wishard Hospital, the LifeCare Program of Clarian Health, Healthnet, and Citizen's Community Health Centers. These sites provide services to residents of Marion and the surrounding counties at little or no cost. The Title III project in northwest Indiana, located within the East Chicago Community Health Center, provides the same types of services to residents of Lake County and its neighboring regions. A relatively new Title III clinic based in Kentucky (Matthew 25 AIDS Services) provides client care in southwest Indiana.

   Finally, Indiana Medicaid serves a large number of HIV+ individuals, providing a comprehensive array of health services to those who meet the strict eligibility requirements. In the year ending 31 March 2005, Indiana Medicaid served more than 1500 individuals with a primary diagnosis of HIV. A combined total of nearly $12.8 million was spent to provide in-patient and out-patient services to these enrollees.

2. HIV-related Medication

   The Division provides access to HIV pharmaceuticals also through its HIV Medical Services Program. The program has two pharmaceutical components: ADAP and HIAP. ADAP provides immediate access to a limited formulary of HIV-related drugs. The formulary is updated regularly and includes all of the drugs that have been

FDA-approved for the treatment of HIV disease. Like EIP, ADAP benefits expire after approximately three months, at which time HIAP becomes effective. More comprehensive than ADAP, HIAP provides access to most FDA-approved pharmaceuticals through its full coverage insurance benefits. ADAP is available to Indiana residents who are HIV+, who earn less than 300% of the federal poverty level, and who are otherwise uninsured. HIAP is available to these same residents but only until the age of 65. As stated earlier, the Division allotted more than $10 million to maintain its medical services in FY2006-2007. The Division also reclaims approximately $240,000 annually in drug rebates from the pharmaceutical industry; these funds are always directly re-applied to the ADAP budget.

Also as noted above, Indiana Medicaid regularly serves more than 1500 individuals with a primary diagnosis of HIV annually. In the year ending 31 March 2005, nearly $17.2 million was spent to provide pharmaceutical services to eligible Medicaid enrollees with an HIV diagnosis code. This is known to include nearly $10.5 million on anti-retroviral therapies alone for the period.

Nearly all of the HIV drug manufacturers sponsor emergency or "indigent" assistance programs for patients without the ability to pay for certain medications. These programs offer a limited supply of medication and are designed to allow the patient time to arrange for other pharmaceutical coverage. HIV Care Coordinators are trained to assist clients with applying for these programs.

Some hospitals in Indiana offer special assistance programs for low-income patients. Wishard Hospital in Indianapolis, for example, operates the Wishard Advantage program which provides in-patient, out-patient, and pharmaceutical services on a sliding scale payment basis to residents of Marion County.

3. Oral Health

In 2005, the Division added a limited number of dental services to its EIP formulary. The covered services include initial prophylaxis, periodic exams, and panoramic x-rays. These oral health care benefits expire when the HIAP plan begins; dental care is not covered by the high-risk insurance pool. To address this concern, the Division of HIV/STD, working in conjunction with the Division of Oral Health, disseminates to its HIV Care Coordination network a statewide directory of dental clinics for low-income individuals.

In central Indiana, the Marion County Health Department uses a portion of its Title III funding to offer dental services through the Regenstrief and Marrott dental clinics in Indianapolis. There are currently no service caps. Consumers are responsible for a small co-payment per service based on a sliding pay scale. The Title III project in northwest Indiana offers dental services through an arrangement with Premier Dental, a major dental provider for HIV+ persons in the area. Under this program, eligible patients are allowed up to $1200 worth of free dental services per year. The Title III project in southwest Indiana, Matthew 25, uses a portion of its funds to pay for routine dental services. Dental treatment plans are reviewed by the program administrator and approved for payment pending the availability of funds.

Indiana Medicaid covers the largest array of dental procedures. However, the program imposes a $600 annual cap on dental services per member. Once this threshold is reached, the member must optimize other resources such as the low-income dental clinics.

4. Case Management

The Division, using funding from the state and from a block grant, currently operates a statewide network of more than 60 case managers stationed at thirteen standard and two clinical HIV Care Coordination sites. (The Marion County Health Department supplements this program by providing Title III funding for an additional case manager at one of the central Indiana care sites.) Each standard site provides comprehensive case management services to consumers seeking assistance. The clinical sites provide similar services in a clinic setting where medical services are also available. The HIV Care Coordination program serves approximately 3000 individuals per quarter.

The program consists of goal-oriented activities that serve to locate, facilitate access to, and monitor the full range of HIV-related services in cooperation with the client. It encourages the most cost-effective use of medical and community resources and promotes the overall well-being of the individual. It respects cultural diversity, emphasizes confidentiality, and strives to ensure the client's freedom of choice and self-determination. Its comprehensive and compassionate services are rendered in a safe, secure, and non-judgmental environment and are provided without cost to the client. The Division currently expends approximately $2.7 million annually

to maintain its 15 care sites, its series of continuing education trainings, and its related quality management activities.

5. Mental Health Treatment
   The Division's role in addressing mental health care is limited to the services available through HIAP and the associated insurance policy. HIAP enrollees are covered for only 20 out-patient visits for mental health and substance use issues combined. In-patient visits are limited to a combined 180 days for major medical, mental health, and substance abuse treatment.

   The mental health care benefits of the state's Title III programs can be even more limited. Services are generally provided through local contracted mental health care facilities and usually include bio-psychosocial assessment, psychiatric evaluation, psychological evaluation, individualized counseling, and group and (in some areas) family support.

6. Substance Abuse Treatment
   Annually, Indiana's Department of Mental Health and Addiction (DMHA) receives an award according to Title 45, Part 96, Subpart L of the Code of Federal Regulations. DMHA subcontracts a small portion of the state's annual award (currently approximately $900,000) to the Division to implement Special Populations Support Program (SPSP) services. The Division, in turn, grants awards to specific entities in different communities throughout the state to perform the necessary testing and supportive care activities.

   SPSP also employs certified HIV testing counselors who have been specially trained to perform comprehensive risk assessments, pre-test counseling, testing, post-test counseling with the substance using population. The testing counselors conduct their testing activities in a variety of venues where the target population can be found, including the statewide treatment facilities sanctioned by the DMHA.

   HIV+ individuals are referred on to the program's support specialists who engage the consumer with interventions designed to minimize substance use and maximize compliance with all applicable treatment plans. The specialists work closely with the local HIV Care Coordination agency to ensure that the consumer receives a full compliment of care.

   Overall, SPSP strives to minimize the negative impact of substance use on the health of persons at risk for or living with HIV disease. The Division currently funds a total of twelve agencies across the state to provide these free SPSP services. Four agencies provide supportive care, four provide counseling and testing services, and four provide both of the components of care offered through this unique program.

   The Division also addresses substance abuse treatment through HIAP and the associated insurance policy. As stated earlier, HIAP enrollees are covered for only 20 out-patient visits for mental health and substance use issues combined. In-patient visits are limited to a combined 180 days for major medical, mental health, and substance abuse treatment.

   The addictions treatment benefits offered through the state's Title III programs are equally limited. Services are generally provided through local contracted treatment facilities and usually include bio-psychosocial assessment, psychiatric evaluation, psychological evaluation, individualized counseling, group and (in some areas) family support, and referral to detoxification.

7. Transportation
   Indiana is without an organized transportation solution for HIV+ individuals. However, a few small programs are available in select areas. First, various limited modes of transport are provided through Medicaid for eligible individuals. These services are provided only for medically necessary travel. In Marion County, the Emerging Communities Initiative's HIV Support Center can transport clients from provider to provider if no other option is available. Also, each Title III clinical care site in the state has a small portion of funding available to assist with the transportation needs of their patients.

8. Housing
   There are no housing programs operated through CARE Act funds in Indiana. HOPWA is the only major program for HIV+ persons seeking housing and utility assistance. The Indiana Housing and Community Development Authority receive funding from the Office of Housing and Urban Development to administer the program. It, in turn, distributes allocations to the regional HIV Care Coordination sites to provide rental or emergency housing

assistance to low-income HIV+ persons living in their area. (Recipients also must be actively engaged in case management services to qualify.) The duration of the assistance can range from one to twelve months, based on the determination of the project sponsors. The 2005 allocation for the state (excluding central Indiana) is $806,000.

The Department of Metropolitan Development (Division of Community Development and Financial Services) administers the HOPWA grant for the City of Indianapolis. This grant serves the Indianapolis Metropolitan Statistical Area of central Indiana, which includes Marion, Boon, Hamilton, Hancock, Hendricks, Johnson, Madison, Morgan, and Shelby Counties. The City of Indianapolis, as the fiscal agent, apportions these funds among several service providers in the region to provide the same type of housing assistance and support services that are available through the HOPWA program in the rest of the state. The City's HOPWA allocation for 2005 is roughly equivalent to that for the entire rest of the state.

Resource Inventory

The continuum of care is naturally dependent on the availability of quality service providers. The tables which appear on the following pages briefly describe the state's key provider(s) for each priority service need for each of the twelve defined service regions. The tables also indicate how consumers can pay for the services and how many other viable options for the service are available. These entities or programs were identified by members of the Comprehensive HIV Services Planning and Advisory Council from the respective regions based on direct and – in most cases – extensive experience with the noted providers.

Region 1 – serving Lake County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	East Chicago Health Center East Chicago, IN	Primary care and laboratory services	Accepts all insurance and sliding scale payments; no fee if under 200% of FPL	3
HIV Medications	Statscript Pharmacy Indianapolis, IN	Mail order pharmacy	Accepts all insurance, ADAP, Medicaid, and Title III payments	1
Oral Health	Premier Dental Merrillville, IN	General dentistry	Accepts private and Title III payments	10
Case Management	Aliveness Project Gary, IN	HIV Care Coordination	No fee for service	0
Mental Health Treatment	Tri-City Mental Health East Chicago, IN	In-patient and out-patient counseling (individual and group)	Accepts all insurance and sliding scale payments	4
	Edgewater Systems Gary, IN	Individual in- and out-patient counseling	Accepts most insurance, Medicaid, Medicare, and sliding scale payments	
Substance Abuse Treatment	Tri-City Mental Health East Chicago, IN	In-patient addictions rehabilitation programs	Accepts all insurance and sliding scale payments	4
	Edgewater Systems Gary, IN	Individual out-patient addictions counseling and Methadone maintenance	Accepts most insurance, Medicaid, Medicare, and sliding scale payments	
Transportation	None Available	--	--	--
Housing	Greater Hammond Hammond, IN	Tenant-Based Rental Assistance (including HOPWA)	Requires client to pay 30% of income as rent	2

Region 2 – serving St. Joseph County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	Dr. Robert Clausen South Bend, IN	Allergy, asthma and clinical immunology	Accepts all insurance and Medicaid	1
HIV Medications	Statscript Pharmacy Indianapolis, IN	Mail order pharmacy	Accepts all insurance, ADAP, Medicaid, and Title III payments	5
Oral Health	Dr. Mark Greene South Bend, IN	General dentistry	Accepts all insurance and Medicaid	20
Case Management	AIDS Ministries South Bend, IN	HIV Care Coordination	No fee for service	0
Mental Health Treatment	Bonhomie Counseling South Bend, IN	Individual out-patient counseling	Accepts all insurance and Medicaid	2
	Madison Center South Bend, IN	Individual out-patient counseling	Accepts most insurance, Medicaid, Medicare, and sliding scale payments	
Substance Abuse Treatment	New Passages South Bend, IN	Individual out-patient addictions counseling	Accepts Medicaid; no fee for uninsured	12
Transportation	AIDS Ministries South Bend, IN	Provision of bus passes	No fee for service	0
Housing	AIDS Ministries South Bend, IN	Long- and short-term HOPWA rental assistance	Requires client to pay 30% of income as rent; if client has no income, program will pay FMR	6

Region 3 – serving Allen County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	Infectious Disease Associates Fort Wayne, IN	Infectious disease specialty care	Accepts all insurance, Medicaid, and Medicare	3
HIV Medications	Walgreen's Pharmacy Fort Wayne, IN	Retail Pharmacy	Accepts all insurance and Medicaid	40
Oral Health	Neighborhood Health Clinic Fort Wayne, IN	General dentistry	Accepts all insurances	10
Case Management	AIDS Task Force Fort Wayne, IN	HIV Care Coordination	No fee for services	0
Mental Health Treatment	Park Center Fort Wayne, IN	Individual out-patient counseling	Accepts all insurance and Medicaid	5
Substance Abuse Treatment	Bowen Center Fort Wayne, IN	In- and out-patient addictions counseling (individual and family)	Accepts all insurance and Medicaid	5
Transportation	Citilink Bus Company Fort Wayne, IN	Public bus service	Accepts cash only	1
Housing	AIDS Task Force Fort Wayne, IN	Limited residential housing	No fee for service	4

Region 4– serving Tippecanoe County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	Tippecanoe County Health Department Lafayette, IN	Primary care services	Accepts most insurance and Medicaid	10
	Arnett Clinic Lafayette, IN	Infectious disease specialty care	Accepts Medicaid	
HIV Medications	Statscript Pharmacy Indianapolis, IN	Mail order pharmacy	Accepts all insurance, ADAP, Medicaid, and Title III payments	4
Oral Health	Community Dental Clinic Lafayette, IN	General dentistry	Accepts Medicaid and cash payments	25
Case Management	Center for Mental Health Lafayette, IN	HIV Care Coordination	No fee for service	1
Mental Health Treatment	Wabash Valley Hospital Lafayette, IN	Individual in- and out-patient counseling	Accepts Medicaid and sliding scale payments	9
	Alpine Clinic Lafayette, IN	In- and out-patient counseling (individual, group, and family)	Accepts sliding scale payments; does not accept Medicaid	
Substance Abuse Treatment	Wabash Valley Hospital Outpatient Lafayette, IN	Individual out-patient addictions counseling	Accepts Medicaid and sliding scale payments	8
Transportation	CityBus 1250 Canal Rd. Lafayette, IN 47904	Public bus service	Accepts cash	4
Housing	Lafayette Housing Authority Lafayette, IN	Subsidized housing (currently has waiting list)	Accepts cash; payment based on income and housing type	5

Region 5 – serving Delaware County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	Medicine Clinic Ball State Memorial Hospital Muncie, IN	Primary and HIV specialty care	Accepts most insurance	3
HIV Medications	Statscript Pharmacy Indianapolis, IN	Mail order pharmacy	Accepts all insurance, ADAP, Medicaid, and Title III payments	31
Oral Health	Open Door Community Services Muncie, IN	General dentistry	Accepts most insurance and sliding scale payments	53
Case Management	Comprehensive Mental Health Services, Inc. Muncie, IN	HIV Care Coordination	No fee for service	0
Mental Health Treatment	Comprehensive Mental Health Services, Inc. Muncie, IN	Individual out-patient counseling and access to psychopharmacol-ogical medications	Accepts most insurance and sliding scale payments	15
Substance Abuse Treatment	Comprehensive Mental Health Services, Inc. Muncie, IN	Out-patient addictions counseling (individual and group)	Accepts most insurance and sliding scale payments	6
Transportation	MITS Bus – MITS+ Muncie, IN	Medical-related transportation services	Accepts cash only ($2 round trip)	1
Housing	Muncie Housing Authority Muncie, IN	Subsidized housing (limited availability)	Accepts cash; payment based on income and housing type	3

Region 6 – serving Madison County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	Madison County Community Health Center Anderson, IN	Primary care, laboratory, and x-ray services	Accepts most insurance, Medicaid, Medicare, and sliding scale payments	4
HIV Medications	Statscript Pharmacy Indianapolis, IN	Mail order pharmacy	Accepts all insurance, ADAP, Medicaid, and Title III payments	2
Oral Health	Madison County Community Health Center Anderson, IN	General dentistry	Accepts most insurance, Medicaid, Medicare, and sliding scale payments	2
Case Management	The Center for Mental Health Anderson, IN	HIV Care Coordination	No fee for service	0
Mental Health Treatment	The Center for Mental Health Anderson, IN	Out-patient counseling (individual and group)	Accepts most insurance, Medicaid, and sliding scale payments	5
Substance Abuse Treatment	The Center for Mental Health Anderson, IN	Individual out-patient addictions counseling	Accepts most insurance, Medicaid, and sliding scale payments	5
Transportation	Prime Source Anderson, IN	Medical-related transportation services	Accepts Medicaid only	4
Housing	Anderson Housing Authority Anderson, IN	Subsidized housing (currently has waiting list)	Accepts cash; payment based on income and housing type	0

Region 7 – serving Marion County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	Wishard Infectious Disease Clinic Indianapolis, IN	Primary and infectious disease specialty care, and access to nutritional services and clinical trials	Accepts most insurance, Medicaid, Medicare, Title III, Wishard Advantage, and sliding scale payments	10
HIV Medications	Statscript Pharmacy Indianapolis, IN	Mail order and retail pharmacy	Accepts all insurance, ADAP, Medicaid, and Title III payments	3
Oral Health	Citizens Dental Indianapolis, IN	General dentistry; referrals for oral surgery	Accepts Title III and Medicaid	4
Case Management	The Damien Center Indianapolis, IN	HIV Care Coordination	No fee for service	3
Mental Health Treatment	Midtown Mental Health Indianapolis, IN	Individual in- and out-patient counseling with psychiatric oversight	Accepts Medicaid, Title III, and Wishard Advantage	3
Substance Abuse Treatment	The Damien Center Indianapolis, IN	SPSP Support Specialist services	No fee for service	6
Transportation	The Damien Center Indianapolis, IN	Bus tickets (single ride and all day bus passes)	No fee for service	3
Housing	The Damien Center Indianapolis, IN	Long- and short-term HOPWA rental assistance	Requires client to pay 30% of income as rent	2

Region 8 – serving Vigo County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	Dr. Jaffri Terre Haute, IN	Primary and infectious disease specialty care	Accepts most insurance, Medicaid, Medicare, and cash payments	2
HIV Medications	Statscript Pharmacy Indianapolis, IN	Mail order pharmacy	Accepts all insurance, ADAP, Medicaid, and Title III payments	10
Oral Health	Affordable Dentures Terre Haute, IN	General dentistry and dentures	Accepts most insurance, Medicaid, and cash payments	10
Case Management	Area 7 Agency on Aging and Disability Terre Haute, IN	HIV Care Coordination	No fee for service	0
Mental Health Treatment	Hamilton Center Terre Haute, IN	Individual out-patient counseling	Accepts all insurance, Medicaid, Medicare, and sliding scale payments	8
Substance Abuse Treatment	Hamilton Center Terre Haute, IN	Individual out-patient addictions counseling	Accepts all insurance, Medicaid, Medicare, and sliding scale payments	2
Transportation	Area 7 Agency on Aging and Disability Terre Haute, IN	Medical-related transportation services	No fee for service	4
Housing	Terre Haute Housing Authority Terre Haute, IN	Subsidized housing	Accepts cash; payment based on income and housing type	12

Region 9 – serving Wayne County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	Wayne County Health Clinic Richmond, IN	Primary care services including HIV and STD testing	Accepts most insurance, Medicaid, Medicare, and sliding scale payments	8
HIV Medications	Statscript Pharmacy Indianapolis, IN	Mail order pharmacy	Accepts all insurance, ADAP, Medicaid, and Title III payments	4
Oral Health	Citizens Health Center Indianapolis, IN	General dentistry	Accepts sliding scale payments	2
Case Management	Center for Mental Health Richmond, IN	HIV Care Coordination	No fee for service	0
Mental Health Treatment	Dunn Center Richmond, IN	Out-patient counseling (individual and group)	Accepts most insurance, Medicaid, and sliding scale payments	10
	Center for Creative Growth Richmond, IN	Individual out-patient counseling	Accepts most insurance and Medicaid payments	
Substance Abuse Treatment	Dunn Center Richmond, IN	Out-patient addictions counseling (individual and group)	Accepts most insurance, Medicaid, and sliding scale payments	5
Transportation	Care-A-Van Richmond, IN	Medical-related transportation services	Accepts Medicaid only	2
Housing	Richmond Housing Authority Richmond, IN	Subsidized housing	Accepts cash; payment based on income and housing type	13

Region 10 – serving Monroe County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	Dr. Tom Hrisolamos Bloomington, IN	Infectious disease specialty care	Accepts all insurance, Medicaid, Medicare, cash payments	4
HIV Medications	Statscript Pharmacy Indianapolis, IN	Mail order pharmacy	Accepts all insurance, ADAP, Medicaid, and Title III payments	6
Oral Health	Dr. Clark Brewer, DDS Bloomington, IN	General dentistry	Accepts most insurance, Medicaid, and cash payments	4
Case Management	Bloomington Hospital's Positive Link Bloomington, IN	HIV Care Coordination	No fee for service	0
Mental Health Treatment	Psychiatric and Counseling Services Bloomington, IN	Individual out-patient counseling	Accepts most insurance, Medicaid, and cash payments	7
Substance Abuse Treatment	Center for Behavioral Health Bloomington, IN	Individual out-patient addictions counseling	Accepts most insurance, Medicaid, and sliding scale payments	5
Transportation	Bloomington Transit Bloomington, IN	Public bus service	Accepts cash only	3
Housing	Bloomington Housing Authority Bloomington, IN	Subsidized housing	Accepts cash; payment based on income and housing type	3

Region 11 – serving Clark County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	University of Louisville WINGS Clinic Louisville, KY	Infectious disease specialty care	Accepts most insurance, Medicaid, Medicare, and sliding scale payments	4
HIV Medications	Statscript Pharmacy Indianapolis, IN	Mail order pharmacy	Accepts all insurance, ADAP, Medicaid, and Title III payments	6
Oral Health	University of Louisville School of Dentistry Louisville, KY	General dentistry (through the Ryan White Care Act)	No fee for service for HIV+ patients	0
Case Management	Clark County Health Department Jeffersonville, IN 47130	HIV Care Coordination	No fee for service	0
Mental Health Treatment	LifeSprings Jeffersonville, IN	Individual out-patient counseling	Accepts most insurance, Medicaid, Medicare, and sliding scale payments	1
Substance Abuse Treatment	Turning Point Jeffersonville, IN	Out-patient addictions counseling (individual, family, and group), and in-patient detox	Accepts most insurance, Medicaid, Medicare, and sliding scale payments	4
Transportation	Mainstream Transport Clarksville, IN 47129	Medical-related transportation services	Accepts Medicaid only	6
Housing	Clark County Health Department Jeffersonville, IN	Long- and short-term HOPWA rental assistance	Requires client to pay 30% of income as rent	1

Region 12 – serving Vanderburgh County and Surrounding Areas

Service Need	Provider Name and Location	Service Description	Payment Options	Other Options
Primary Medical Care	Dr. Jose Salgado Evansville, IN	Infectious disease specialty care	Accepts all insurance, Medicaid, and cash payments	1
	Dr. Romelle Belmonte Evansville, IN	Infectious disease specialty care	Accepts all insurance, Medicaid, and cash payments	
HIV Medications	Statscript Pharmacy Indianapolis, IN	Mail order pharmacy	Accepts all insurance, ADAP, Medicaid, and Title III payments	6
Oral Health	Impact Christian Health Evansville, IN	General dentistry	Accepts cash only (at reduced rates)	5
Case Management	AIDS Resource Group Evansville, IN	HIV Care Coordination	No fee for service	0
Mental Health Treatment	Southwestern Indiana Mental Health Center Evansville, IN	Individual out-patient counseling and psychiatric evaluation	Accepts most insurance, Medicaid, and sliding scale payments	10
Substance Abuse Treatment	Stepping Stone Evansville, IN	Out-patient counseling (individual and group) and in-patient detox	Accepts most insurance, Medicaid, and sliding scale payments	17
Transportation	AIDS Resource Group Evansville, IN	Volunteer transportation services and bus tickets	No fee for service	1
Housing	AIDS Resource Group Evansville, IN	Long- and short-term HOPWA rental assistance	Requires client to pay 30% of income as rent; if client has no income, program will pay FMR	40

Profile of CARE Act Providers

Indiana receives Title II, Title III, and Part F funds through the Ryan White CARE Act. Part F supports the Midwest AIDS Training and Education Center which is not considered to be a service provider. Title III funds are awarded to the Marion County Health Department and the East Chicago Community Health Center and are administered internally. A third Title III provider, Matthew 25 AIDS Services, is based in Northern Kentucky but serves a section of Southern Indiana. Title II funds are awarded to ISDH and administered by the Division. The vast majority of CARE Act funds are used to address the highest priority service needs: primary medical care and HIV-related medications.

The Marion County Health Department (MCHD) houses the state's largest Title III Program which serves Marion County and its eight contiguous counties. MCHD employs two Title III Program staff: a Title III Project Director and a Title III Quality Assurance Coordinator. The Director monitors and coordinates the activities of subcontractors to ensure that the goals and objectives of the Title III Program are carried out in accordance with federal guidelines. The Quality Assurance Coordinator implements and monitors quality assurance programs to ensure that HIV standards of care are followed.

In order to meet the needs of the community, the Title III Program provides early and easy access to primary medical care in neighborhoods most affected by HIV. Infected and at-risk populations can access services through neighborhood clinics and a hospital-based clinic. Once enrolled in the Title III program in Marion County, patients can access care at any affiliated provider regardless of their geographic location.

The strength of Marion County's Title III program derives from a coordinated system of care developed through collaborative relationships with six community health centers located in federally designated Medically Underserved Areas and Health Professional Shortage Areas, two hospital-based clinics that are also satellites for the AIDS Clinical Trials Group, Marion County's largest AIDS Service Organization, and MCHD. This coordinated system of care provides access to quality primary care services and social services for our targeted population.

The Marion County Title III Program provides access to a variety of services, including primary medical care, infectious disease specialty services, and pharmaceutical services. Specialty referrals can be made for dentistry, gynecology, obstetrics, cardiology, psychiatry, podiatry, gastroenterology, neurology, dermatology, and ophthalmology. The program can also provide access to HIV Care Coordination, mental health and addictions counseling, and nutrition education. Comprehensive oral health care is offered through three main providers: Indiana University School of Dentistry, the Pecar Dental Clinic, and Citizens Health Center. Services available to all clients include an initial dental examination, two cleanings per year, preventive and restorative care, fillings, extractions and minor surgery.

Adherence education is a key component of routine medical visits and also of the general HIV counseling sessions provided to all newly diagnosed patients. The Title III Program funds a part-time pharmacist who specializes in HIV and who works closely with the Wishard Infectious Disease Clinic, providing adherence counseling to the clinic patients. Every patient who is initiated on anti-retroviral therapy (including those who change therapy) is counseled regarding medication doses, medication schedules, food restrictions, storage, common side effects, and drug resistance due to non-adherence. Adherence counseling is also scheduled outside of clinic times for patients requiring intensive educational sessions. This includes counseling regarding newer, complicated therapies, such as peglated interferon for treatment of Hepatitis C, Fuzeon injection for HIV, or sessions for very complicated medication regimens that require more educational intervention.

Mental health and substance abuse treatment services are provided at Midtown Community Mental Health Center. Clinicians and HIV Care Coordinators can refer individuals to Midtown where they can receive outpatient mental health and substance abuse services that include, but are not limited to, bio-psychosocial assessment, psychiatric and psychological evaluations, individualized counseling sessions, group support, and treatment referrals (e.g., to Midtown's Methadone Center).

Nutritional services are offered through a registered dietitian who provides individual and group nutrition education sessions and nutrition consultations. Nutrition consultants assess a client's nutrition status by reviewing anthropometric and laboratory data, medication side effects, diet history, food acquisition issues, and any lifestyle activities that may affect nutrition status (e.g., homelessness, substance abuse, etc.). Individual and group nutrition education sessions may focus on one or multiple topics. The nutritionist can assist the client in developing a personalized program by assessing the client's weight, eating habits, prescribed medication and lifestyle. Bioelectrical Impedance Analysis is used to assess a client's possible wasting, as well as to quantify fat mass and lean

body mass. Fat mass, lean body mass, body cell mass, and body mass index are tracked over time. Clients are then scheduled to return every six months for a follow-up evaluation.

Much smaller in scope, the East Chicago Community Health Center (ECCHC) serves the northwestern portion of the state. It is a primary care and treatment program providing people with HIV access to all of the ECCHC medical providers. These include mid-level practitioners, internist, pediatricians, obstetricians, and gynecologists. Patients are provided primary care regardless of their ability to pay. ECCHC uses a sliding-fee schedule for patients; patients under 200% of poverty pay $0 for their medical care, laboratory, and medication expense. All forms of insurance are accepted.

ECCHC participates in the 340b Drug Pricing program and purchases HIV medication for patients at a discount. Medication is dispensed at a local pharmacy, Fagen Pharmacy. Currently, Title III patients have access to oral health services and specialty care through a subcontractor. ECCHC anticipates introducing comprehensive oral health services by early spring of 2006. HIV+ patients receive referrals to the case management services provided through the Aliveness Project of Northwest Indiana. Mental and substance abuse services are available by referral to Tri-City Mental Health. The program also conducts free HIV testing and counseling.

A third Title III clinic is funded in Henderson, KY and serves portions of Southern Indiana, including Evansville. Matthew 25 provides most of its HIV services at no cost or according to a sliding-scale fee schedule. Their services include primary medical care, adherence counseling, prevention case management, transportation assistance, and access to a food pantry. Specialty referrals can be made for substance abuse, dental, and psychiatric care.

Due to the manner in which the majority of services are delivered (via the insurance-based HIV Medical Services Program), Title II funds are largely administered directly by ISDH. Subcontractors are limited to those participating in the Emerging Communities Initiative. These include Wishard Hospital (working with Indiana University), Clarian Health, and the Bethlehem House. Wishard and Clarian each use the ED funds to support additional clinic staff who can address the needs of the Emerging Communities target population which includes those patients at high risk for disengaging from care due to homelessness, substance abuse, or mental illness. Each clinic currently employs two nurse practitioners and one medical assistant.

The Bethlehem House houses the HIV Support Center. This is a specialized "safety net" project, created to provide intensive support services to keep the consumer in care. It works to ensure that consumers appear for appointments and follow the prescribed care plans for maximum positive health outcomes. The HIV Support Center currently employs eight "care partners" who work exclusively with the high-risk Emerging Communities population noted above.

Barriers To Care

Despite a healthy continuum of care, a wealth of quality service providers, and a focused group of CARE Act programs, HIV+ individuals in Indiana still encounter a variety of barriers to health care and social services. The following paragraphs briefly describe the most evident barriers for each priority service need. These barriers include both the obstacles experienced by the consumer and those facing the providers.

1. Primary Medical Care
    - Many consumers lack insurance coverage or are unable to pay for services.
    - Despite the Division's funding commitment, the HIV Medical Services Program is unable to serve all of its eligible applicants. The enrollment threshold for the number of enrollees has been reached. A waiting list is in place at this time, and the maximum capacity could be reduced during FY2006-2007 if further premium increases are realized.
    - Although an application has been made for Title III funds in northeast Indiana, primary medical care services supported by these funds are limited to central, southwest, and northwest Indiana.
    - The number of infectious disease specialists is low. General practitioners may be reluctant to treat HIV+ patients in large numbers due to the complexity of the disease. Low volume providers often have less experience and less training, and this may impact the health outcomes experienced by their patients over time.
    - The degree to which clients are able to comprehend and successfully use the Division's HIV Medical Services Program is a concern, particularly for consumers of diverse racial or ethnic backgrounds.
    - The consumer's physical health can prevent timely access to appropriate medical care or may interfere with adherence to prescribed regimens.

- Organizational barriers such as "navigating the system," "dealing with red tape," and "coordinating services" are often cited by consumers.
- ICHIA has changed its residency requirement from 90 to 365 days; the Division is not financially able to provide ADAP and EIP services during the "holding" period.
- ICHIA has eliminated its list of qualifying conditions for eligibility and, instead, requires applicants to provide proof of a denial from a private insurance provider.
- ICHIA now requires that each applicant file a Medicaid application. This is a significant barrier to people who are not U.S. citizens.

2. HIV-related Medication
   - Limited funding for the Title II-supported HIV Medical Services Program is the most immediate barrier to pharmaceutical access for uninsured HIV+ individuals. Despite the Division's funding commitment, the HIV Medical Services Program is unable to serve all of its eligible applicants. The enrollment threshold for the number of enrollees has been reached. A waiting list is in place at this time, and the maximum capacity could be reduced during FY2006-2007 if further premium increases are realized.
   - Hospital-based assistance programs for low-income patients are not available statewide.
   - Medicaid offers pharmaceutical coverage comparable to that of the HIV Medical Services Program; however, the enrollment process is lengthy and the eligibility standards (which often require applicants be determined disabled by the State Medical Review Team) exclude a large number of potential enrollees.
   - The Medicaid guidelines do not allow the recipients to earn an adequate income without jeopardizing their coverage.
   - Medicaid requires prior authorization for drugs that are not part of its standard formulary. There are currently several important HIV drugs that are not a part of the Medicaid formulary.
   - The cost of many of the medications is prohibitive for consumers who do not qualify for public assistance programs.
   - The manufacturer-sponsored indigent drug assistance programs are short-term, and the application process is cumbersome for consumers (especially those without case management assistance).
   - Adverse side effects and potential drug interactions may prevent consumers from accessing HIV pharmaceuticals when they are available to them.

3. Oral Health
   - The out-of-pocket costs for dental care can be prohibitive to many HIV+ consumers.
   - The Title II HIV Medical Services Program includes only a short-term dental component.
   - ICHIA has no dental benefit.
   - The Title III dental services are limited to certain clinic-based providers and are only available in three areas of the state.
   - Many private dental providers do not accept Medicaid or have waiting lists for Medicaid patients.
   - Many private dentists are not prepared to manage the special oral health needs of those with HIV disease.
   - Some dental providers in rural areas are unwilling to treat patients with HIV.

4. Case Management
   - Staffing statewide is not adequate to meet demand. More than half of the HIV Care Coordination sites within the ISDH network are managing caseloads that exceed the maximum acceptable case manager-to-client ratio of 1:40.
   - State block grant funding for the HIV Care Coordination Program has been decreased 20% between 2001 and 2006.
   - "Life issues" are proving to be harder to manage than "death issues." As clients live longer, their needs have evolved to include issues that previously would not have been within the scope of HIV case management. These issues include employment, family planning, and budget counseling. Clients with multiple health issues are particularly difficult to manage.
   - HIV Care Coordinators are not uniformly knowledgeable about issues and services that are unique to women, children, and families.
   - Due to lack of state services, many case managers are beginning to develop a sense of hopelessness about their ability to improve the lives of their clients.
   - HIV Care Coordination sites are not uniformly equipped to manage non-English speaking consumers.
   - HIV Care Coordination programs are not adequately funded to allow for sufficient outreach efforts to take place in under-served populations.

- HIV Care Coordination programs are not adequately funded to allow for the development of targeted support programs (e.g., peer support, group support, educational workshops) for specialized populations (e.g., detainees, sex workers, women, children, minority groups).
- Complementary support programs (such as the HIV Support Center and the Special Populations Support Program) are not available in every area of the state.
- The manner in which case management is assessed (i.e., comparison of actual vs. target service provision) can become a disincentive to collaboration among agencies.

5. Mental Health Treatment
   - The out-of-pocket costs for mental health care can be prohibitive to many HIV+ consumers.
   - The Title II HIV Medical Services Program provides for only limited access to psychotropic medications and for no psychiatric services until insurance begins.
   - ICHIA allows for coverage of only 20 out-patient visits for mental health and substance use issues combined. In-patient visits are limited to a combined 180 days for major medical, mental health, and substance abuse treatment.
   - The Title III mental health services are limited to certain clinic-based providers and are only available in three areas of the state.
   - Many private mental health providers do not accept Medicaid or have waiting lists for Medicaid patients.
   - Many traditional mental health providers are not equipped to address the disclosure, sexual, and chronic illness issues that may accompany an HIV+ diagnosis.

6. Substance Abuse Treatment
   - The out-of-pocket costs for addictions treatment can be prohibitive to many HIV+ consumers.
   - The Title II HIV Medical Services Program provides for only very limited access to withdrawal management medications and for addictions treatment services until insurance begins.
   - ICHIA allows for coverage of only 20 out-patient visits for mental health and substance use issues combined. In-patient visits are limited to a combined 180 days for major medical, mental health, and substance abuse treatment.
   - The Title III substance abuse services are limited to certain clinic-based providers and are only available in three areas of the state.
   - Many substance abuse treatment facilities have waiting lists for Medicaid patients.
   - Many areas of the state have no local substance abuse treatment facilities.

7. Transportation
   - Neither Title II nor Title III operates a large-scale transportation program currently.
   - Affordable public transportation in rural (and some suburban) areas is scarce. Where available, public transportation can be difficult to use for consumers with children.
   - Personal transportation is often unaffordable for HIV+ persons who are unemployed or living on a limited income.
   - Physical health may prevent some consumers from operating a vehicle or utilizing public transportation.
   - Where transportation options exist, many are not flexible enough to address the amount and frequency of the consumer's medically necessary travel.

8. Housing
   - Housing options (including shelters) are limited for women with children.
   - HOPWA funds are strictly limited and cannot satisfy the demand for assistance; several HOPWA projects maintain waiting lists for assistance.
   - HOPWA and other available options impose limits on the duration of assistance.
   - Waiting lists also exist for many public housing programs, including Section 8.
   - Many available options impose restrictions which prevent certain populations (e.g., the incarcerated) from being eligible for service.

Part 2 – OPTIMAL SYSTEM OF CARE

Recommendations for System Improvements

The Division recognizes the core services established by HRSA: Primary Medical Care, HIV-related Medications, Oral Health, Case Management, Mental Health Treatment, and Substance Abuse Treatment. The Division has identified two additional services – Transportation and Housing – as similarly crucial needs of the HIV+ population. Together, these eight areas form the state's priority service needs. The optimal continuum of care would address each of these areas of need by providing the most comprehensive services possible to the greatest number of high-need HIV+ individuals.

While Indiana has successfully provided for some of these needs, serious barriers and limitations still exist. Advisory board members have developed the following recommendations which are presented in an effort to help service providers address the identified barriers to care for the under-served populations and to provide better quality services.

1. Primary Medical Care
    - The Title II grantee should encourage agencies to apply for Title III and Title IV funds (when available) to ensure access to basic early intervention services statewide.
    - The Title II and the Title III grantees should continue collaborations with the Part F grantee in an effort to identify additional infectious disease specialists in the state and to adequately educate other providers (including non-HIV specialists such as obstetricians, gynecologists, and mental health professionals) regarding HIV disease treatment.
    - The Title II grantee should continue to refine its HIV Medical Services Programs to minimize confusion for both consumers and providers in the areas of program utilization (i.e., how consumers can use the services) and reimbursement (i.e., how providers can bill for the services rendered).
    - The Title II grantee should continue to work closely with the Part F grantee to ensure that case management staff members are provided training that addresses strategies to help improve consumer's experiences with the HIV Medical Services Program.
    - The Title II grantee should work to expand its insurance continuation component to provide comprehensive health insurance coverage to the largest number of eligible individuals possible within its funding constraints.
    - The Title II grantee should ensure that its HIV Medical Services Program is marketed and explained to consumers in a culturally appropriate manner in order to minimize confusion and to maximize utilization among ethnically diverse populations.
    - The Title II and the Title III grantees should continue collaborations with the HIV Care Coordination programs to ensure that persons in need are offered assistance in addressing needs related to physical limitations, transportation, and health care system navigation.
    - The Title II and Title III grantees should continue close collaborations with HIV testing providers.
    - The Title II and Title III grantees should improve collaborations with the correctional system to guarantee that consumers experience an easy transition from one service component to the next.

2. HIV-related Medication
    - The Title II grantee should continue its efforts to verify the eligibility of every HIV Medical Services Program enrollee to ensure that the program serves only those without access to other resources and to minimize the impact of the waiting list.
    - The Title II and Title III grantees should continue to provide intensive training to its HIV Care Coordination programs to ensure that case managers are able to assist consumers in the speedy navigation of the Medicaid enrollment process.
    - The Title II and Title III grantees should continue collaborations with other service providers to guarantee that emergency financial assistance funds for medications are available statewide to consumers without the necessary resources.
    - The Title II grantee should continue to collaborate with the Part F grantee to provide specialized training to the HIV Care Coordination providers to ensure that case managers are able to efficiently access the assistance available through manufacturer-sponsored indigent drug assistance programs.
    - The Part F grantee should continue to include information regarding side effects, drug interactions, and strategies to increase adherence to prescribed regimens in its education of physicians and social service providers.
    - The Title II grantee should continue its efforts to obtain drug rebates to apply to the ADAP budget.

3. Oral Health
    - The Title II grantee should encourage agencies to apply for Title III funds to improve access to appropriate dental services statewide.
    - The Title II grantee should review the existing formulary for early intervention services to ascertain the feasibility of expanding access to dental services during the pre-existing condition period for the insurance component.
    - The Title III grantees should work to ensure that area physicians, HIV Care Coordination programs, and consumers are aware of the availability of their oral health services.
    - The Title II and Title III providers should continue collaborations with other providers to guarantee that emergency financial assistance remains available for dental expenses. Further, collaborations should be initiated with the Division of Oral Health to research other assistance options that may be available statewide.
    - The Title II and Title III grantees should continue collaborations with the HIV Care Coordination programs to ensure that case managers can effectively negotiate with dental providers for the acceptance of Medicaid as payment for their clients in need.
    - The Part F grantee should increase the training opportunities targeted to dentists to expand the number of providers willing and qualified to serve those with HIV.
    - The Title II grantee should continue to distribute the Division of Oral Health's Dental Clinic Directory to the HIV Care Coordination sites on a regular basis.

4. Case Management
    - The Title II and Title III grantees should support expanded HIV Care Coordination staffing and provide incentives to decrease staff turn-over.
    - In collaboration with Part F, the Title II grantee should continue to provide the most comprehensive skills-building trainings possible for its case management staff. Topics should include the management of clients with mental illness, substance abuse, and domestic abuse issues. Issues regarding women and families, homelessness, poverty, and financial management should also be continually addressed.
    - In collaboration with Part F, the Title II grantee should coordinate an intensive educational workshop for its case management staff. This workshop should provide uniform strategies to help staff manage the changing needs of the client population in a state with limited resources. It should be designed to help case managers empower their clients to make autonomous life decisions. It should also seek to re-energize and encourage the staff (possibly through the use of peer support and mentors).
    - In addition to the cultural competencies that are incorporated into the current training program, the Title II grantee should consider offering (or reimbursing projects for the cost of) Spanish classes as a part of the standard curriculum.
    - The Title II grantee should review available funding sources to determine if some funds could be allocated to support outreach efforts.
    - The Title II grantee should encourage agencies to develop supportive service programs for their specialized populations (such as women and families, ethnic minorities, detainees).
    - The Title II grantee should review the current complementary support programs to ascertain if the projects could be implemented uniformly on a statewide basis.
    - The Title II grantee should identify ways to increase cooperation between care sites.

5. Mental Health Treatment
    - The Title II grantee should encourage agencies to apply for Title III funds to improve access to appropriate mental health services statewide.
    - The Title II grantee should review the existing formulary for early intervention services to ascertain the feasibility of offering access to mental health services during the pre-existing condition period for the insurance component.
    - The Title II and Title III providers should continue collaborations with other providers to ensure that emergency financial assistance is available for mental health care.
    - The Title II and Title III grantees should continue collaborations with the HIV Care Coordination programs to ensure that case managers can effectively negotiate with mental health providers for the acceptance of Medicaid as payment for their clients in need.

6. Substance Abuse Treatment
    - The Title II grantee should encourage agencies to apply for Title III funds to improve access to appropriate addictions treatment statewide.

- The Title II grantee should review the existing formulary for early intervention services to ascertain the feasibility of offering access to addictions treatment during the pre-existing condition period for the insurance component.
- The Title II and Title III providers should continue collaborations with other providers to ensure that emergency financial assistance is available for addictions treatment.
- The Title II and Title III grantees should continue collaborations with the HIV Care Coordination programs to ensure that case managers can effectively negotiate with substance abuse treatment facilities for the acceptance of Medicaid as payment for their clients in need.
- The Title II grantee should continue to expand its Special Populations Support Program to ensure that each region in the state has access to the program's supportive care component.

7. Transportation
   - The Title II and Title III grantees should continue to support service providers, particularly the HIV Care Coordination sites, as they explore innovative solutions to the transportation problem. The concept of a statewide transportation program should be assessed for feasibility.
   - Where public transportation is available, the Title II and Title III grantees should work to ensure that area agencies are aware of the available services.
   - The Title II grantee should research ways to provide transportation and other support services (particularly for marginalized groups such as the mentally ill, substance users, women with children, and detainees) through the existing HIV Care Coordination network.

8. Housing
   - The Title II, Title III, and Part F grantees should support and assist the Indiana Housing and Community Development Authority in its efforts to implement the recommendations described in the Indiana HIV/AIDS Housing Plan.
   - The Title II grantee should research ways to improve access to adequate housing assistance (particularly for marginalized groups such as the mentally ill, substance users, women with children, and detainees) through the existing HIV Care Coordination network.

Guiding Principles

The Ryan White CARE Act grantees and providers are committed to conscientiously addressing Indiana's Statewide Coordinated Statement of Need and to improving the continuum of care. Providing the highest quality services in a cost-effective and equitable manner is a primary concern. Equally important is a commitment to serving those with the least resources, both in monetary terms and with respect to access to services.

Part 3 – SERVICE DELIVERY PLAN

Long-term Goals and Objectives

In order for Indiana to realize an improved system of care, achievement of the following long-term goals and objectives will be necessary. These goals are presented according to four major administrative areas: systems, planning, evaluation, and service. Though the goals are long-term, the deadlines for completion of each objective are set within the next grant period. It is understood that all of the long-term goals will be fully reviewed and updated every three years (i.e., by 1 January 2009).

1. Systems Goal: To improve coordination between major service providers.
   - Objective 1. To reach at least 60% of the full membership level for the Comprehensive HIV Services Planning and Advisory Council (by 1 April 2007).
   - Objective 2. To hold four separate quarterly meetings for Title II, Title III, and Part F grantees (by 31 March 2007).
   - Objective 3. To review the eligibility requirements for all Title II and Title III service components to ensure consistency (by 1 October 2006).
   - Objective 4. To review the benefit information for all Title II and Title III service components to identify and eliminate any overlapping or superfluous services (by 1 April 2007).

2. Planning Goal: To maintain a dynamic Statewide Comprehensive Plan.
   - Objective 1. To evaluate the necessity to conduct a new needs assessment in 2006 (by 1 April 2006).
   - Objective 2. To incorporate the results of any new needs assessment into the Statewide Comprehensive Plan (by 1 July 2006).
   - Objective 3. To obtain and incorporate updated epidemiological information into the Statewide Comprehensive Plan (by 1 October 2006).
   - Objective 4. To create an annual revision of the entire Statewide Comprehensive Plan, incorporating the Statewide Coordination Statement of Need (by 1 November 2006).

3. Evaluation Goal: To document that funded interventions improve health outcomes for the target population.
   - Objective 1. To complete the collection of service utilization data from ICHIA (by 1 February 2006).
   - Objective 2. To complete the creation of database structures to archive and analyze all HIV Medical Services Program utilization information (by 1 March 2006).
   - Objective 3. To establish benchmark health indicators against which to measure health outcomes (by 1 April 2006).
   - Objective 4. To compare current health and service utilization information for participants against the established benchmarks to evaluate the effectiveness of the HIV Medical Services Program (by 1 July 2006).

4. Service Goal: To maintain HIV services statewide at current or expanded levels.
   - Objective 1. To increase ADAP 340B rebate reimbursements by 20% by targeting the top twenty drugs rather than the only the top ten (by 1 July 2006).
   - Objective 2. To review all Title II budget items to determine if funds can be diverted from administrative costs to services (by 1 July 2006).
   - Objective 3. To document qualifying expenditures for HIV services at the level necessary to satisfy the federal funding match and Maintenance of Effort requirements (by 1 April 2007).
   - Objective 4. To implement at least one new full-service potential Title III clinic in Indiana (by 1 April 2008).

Short-term Goals and Objectives

While the state's long-term HIV care goals and objectives are framed in terms of administrative activities, those for the short-term are categorized according to the priority service needs. In some cases, single objectives apply to more than one goal and, therefore, are repeated. Timeframes are indicated where applicable.

1. Primary Medical Care
   a. Goal 1. To continue EIP as a transitory or "safety net" plan for coverage of HIV-related out-patient care for eligible HIV+ persons without adequate health coverage.
      - Objective 1. To require all new EIP applicants in FY2006-2007 to simultaneously submit applications for HIAP and ICHIA.
      - Objective 2. To screen all new EIP applicants for access to Marion County's Title III services.
      - Objective 3. To transition all eligible EIP enrollees into HIAP for comprehensive insurance coverage within five months of the EIP effective date.

b. Goal 2. To continue HIAP as a long-term solution for HIV-related out-patient care for eligible HIV+ persons without adequate health coverage.
   - Objective 1. To require all new HIAP applicants in FY2006-2007 to simultaneously submit applications for Medicaid.
   - Objective 2. To screen all new HIAP applicants for access to private insurance.
   - Objective 3. To recertify each enrollee for continued eligibility annually.

c. Goal 3. To continue to provide efficient and cost-effective EIP and HIAP benefits for all eligible applicants.
   - Objective 1. To renew the current contract for third-party administration of the EIP and HIAP benefits (by 1 January 2007).
   - Objective 2. To ensure that the third-party administrator will maintain processing time at 15 working days or less for 90% of the claims.
   - Objective 3. To ensure that providers will receive payments from the third-party administrator for services rendered within 30 days of claim submission.

d. Goal 4. To promote client adherence to medical treatments.
   - Objective 1. To maintain the relationship between the Title II and Part F grantees in order to ensure that all providers seeking reimbursement under EIP and/or HIAP (at minimum) receive updated versions of the PHS Guidelines and other information related to recommended HIV care.
   - Objective 2. To continue to offer access to information (including via the toll-free HIV Medical Services telephone line) to providers, HIV Care Coordinators, and consumers regarding the HIV Medical Services Program and ICHIA, including information regarding eligibility, enrollment, and the proper reimbursement procedures to assure successful access of services.
   - Objective 3. To provide information to all existing HIV Care Coordinators designed to improve the successfulness of messages to HIV+ clients about the importance of remaining engaged in primary care (by 1 January 2007).

2. HIV-related Medication
   a. Goal 1. To continue ADAP as a transitory or "safety net" plan for coverage of HIV-related prescription drugs for eligible HIV+ persons without adequate health coverage.
      - Objective 1. To require all new ADAP applicants in FY2006-2007 to simultaneously submit applications for HIAP and ICHIA.
      - Objective 2. To transition all eligible ADAP enrollees into HIAP for comprehensive insurance coverage within four months of the ADAP effective date.
      - Objective 3. To provide to all ADAP-eligible applicants who are over the age of 65 and enrolled in a Medicare Part D plan a limited ADAP benefit designed to cover the Part D co-insurance and deductible expenses.

   b. Goal 2. To continue HIAP as a long-term solution for HIV-related pharmaceuticals for eligible HIV+ persons without adequate health coverage.
      - Objective 1. To require all new HIAP applicants in FY2006-2007 to simultaneously submit applications for Medicaid.
      - Objective 2. To screen all new HIAP applicants for access to private insurance.
      - Objective 3. To recertify each enrollee for continued eligibility annually.

   c. Goal 3. To continue to provide efficient and cost-effective pharmacy benefits management and claims processing for ADAP formulary drugs.
      - Objective 1. To renew the current contract for third-party administration of the ADAP benefits (by 1 January 2007).
      - Objective 2. To ensure that the third-party administrator will maintain processing time at 15 working days or less for 90% of the claims.
      - Objective 3. To ensure that providers will receive payments from the third-party administrator for services rendered within 30 days of claim submission.

   d. Goal 4. To promote client adherence to antiretroviral combination therapy regimens.
      - Objective 1. To maintain the relationship between the Title II and Part F grantees in order to ensure that all providers seeking reimbursement under EIP and/or HIAP (at minimum) receive updated versions of the PHS Guidelines and other information related to recommended HIV therapies.

- Objective 2. To continue to offer information and educational opportunities to providers, HIV Care Coordinators, and consumers regarding the HIV Medical Services Program and ICHIA, including the proper reimbursement procedures to assure successful access of services through the programs.
- Objective 3. To provide a "refresher" training to all existing HIV Care Coordinators designed to improve theirs skills for reinforcing the message to HIV+ clients about the importance of adherence to their antiretroviral combination therapy regimens (by 1 January 2007).

e. Goal 4. To provide eligible persons in the Marion County's Emerging Communities target population emergency access to high quality and cost-effective primary care.
- Objective 1. To renew contracts with Emerging Communities clinic providers in Marion County (by 1 January 2007).
- Objective 2. To provide at least 3600 staff hours (through the use of two subsidized clinic projects utilizing Nurse Practitioners in a multidisciplinary team approach to care) to serve eligible Emerging Communities clinic patients (by 1 April 2007).
- Objective 3. To screen all potential patients for eligibility and lack of other resources.

f. Goal 5. To provide eligible persons in the Marion County's Emerging Communities target population access to intensive supportive services designed to prevent disengagement from care.
- Objective 1. To renew contracts with the HIV Support Center provider in Marion County (by 1 January 2007).
- Objective 2. To serve at least 240 distinct persons from underserved minority and hard-to-reach populations (i.e., those affected by substance abuse, homelessness, and mental health disease) using proven behavioral change theory methodologies to assist the consumer in developing the self-efficacy necessary to manage their complicated treatment plans and drug regimens (by 1 April 2007).
- Objective 3. To screen all potential patients for eligibility and to ensure enrollment in long-term case management.

3. Oral Health
   a. Goal 1. To maximize utilization of the existing oral health resources in the state.
      - Objective 1. To create new enrollment materials which highlight the availability of the EIP dental services during the pre-existing condition period for insurance (by 1 July 2006).
      - Objective 2. To continue distribution of the Division of Oral Health's directory of low-cost dental providers to all the HIV Care Coordination agencies.
      - Objective 3. To convene a meeting between CARE Act grantees and potential funders of financial assistance to ensure that dental and other oral health expenses are eligible for reimbursement (by 1 July 2006).

   b. Goal 2. To develop new oral health resources for HIV+ persons in the state.
      - Objective 1. To identify at least one new potential Title III applicant in northern or northeastern Indiana (by 1 January 2007).
      - Objective 2. To review the existing EIP formulary to ascertain the feasibility of expanding the range of dental services offered during the pre-existing condition period (by 1 October 2007).

4. Case Management
   a. Goal 1. To ensure concurrent enrollment in HIV Care Coordination and other major HIV services.
      - Objective 1. To continue to require that each new HIV Medical Services application originates from a funded HIV Care Coordination agency.
      - Objective 2. To continue to require that SPSP and Emerging Communities project staff members continually refer their enrollees back into the case management program for long-term care planning.
      - Objective 3. To continue collaborations between the Division and the Indiana Housing and Communities Development Authority to ensure that HOPWA funds are distributed through the HIV Care Coordination network.

   b. Goal 2. To improve the quality of the HIV Care Coordination Program in Indiana.
      - Objective 1. To continue collaborations between the Division and the Part F grantee to provide regular skills-building trainings for its case management staff on pertinent topics, such as mental illness, substance abuse, domestic violence, homelessness, poverty, and financial management.
      - Objective 2. To continue to perform annual program audits to review documentation, charting, and appropriateness of interventions.

5. Mental Health Treatment
   a. Goal 1. To maximize utilization of the existing mental health resources in the state.
      - Objective 1. To create new enrollment materials which highlight the availability of the psychotropic drugs on the ADAP formulary during the pre-existing condition period for insurance (by 1 July 2006).
      - Objective 2. To convene a meeting between CARE Act grantees and potential funders of financial assistance to ensure that mental health expenses are eligible for reimbursement (by 1 July 2006).

   b. Goal 2. To develop new mental health resources for HIV+ persons in the state.
      - Objective 1. To identify at least one new potential Title III applicant in northern or northeastern Indiana (by 1 January 2007).
      - Objective 2. To review the existing EIP formulary to ascertain the feasibility of offering access to mental health services during the pre-existing condition period (by 1 October 2007).

6. Substance Abuse Treatment
   a. Goal 1. To maximize utilization of the existing addictions treatment resources in the state.
      - Objective 1. To create new enrollment materials which highlight the availability of the withdrawal management drugs on the ADAP formulary during the pre-existing condition period for insurance (by 1 July 2006).
      - Objective 2. To convene a meeting between CARE Act grantees and potential funders of financial assistance to ensure that addictions treatment expenses are eligible for reimbursement (by 1 July 2006).
      - Objective 3. To continue to promote the availability of SPSP supportive care to clinics, treatment facilities, and case management agencies throughout the state.

   b. Goal 2. To develop new mental health resources for HIV+ persons in the state.
      - Objective 1. To identify at least one new potential Title III applicant in northern or northeastern Indiana (by 1 January 2007).
      - Objective 2. To review the existing EIP formulary to ascertain the feasibility of offering access to addictions treatment during the pre-existing condition period (by 1 October 2007).

7. Transportation
   a. Goal 1. To maximize utilization of the existing transportation resources in the state.
      - Objective 1. To compile a directory of regional low-cost transportation options that can distributed to case managers (by 1 October 2006).
      - Objective 2. To convene a meeting between CARE Act grantees and potential funders of financial assistance to ensure that transportation expenses are eligible for reimbursement (by 1 July 2006).

   b. Goal 2. To develop new transportation resources for HIV+ persons in the state.
      - Objective 1. To access the feasibility of developing a statewide transportation solution for HIV+ individuals (by 1 October 2006).
      - Objective 2. To research possible funding sources for developing any statewide transportation solution for HIV+ individuals (by 1 January 2007).

8. Housing
   a. Goal 1. To maximize utilization of the existing housing resources in the state.
      - Objective 1. To compile a directory of regional low-cost housing options that can distributed to case managers (by 1 October 2006).
      - Objective 2. To convene a meeting between CARE Act grantees and potential funders of financial assistance to ensure that housing and shelter-related expenses are eligible for reimbursement (by 1 July 2006).

   b. Goal 2. To continue collaborations between the Division and Indiana Housing and Community Development Authority.
      - Objective 1. To participate in the annual application review for HOPWA awards.
      - Objective 2. To continue to require that HOPWA recipients must also be funded by the Division to perform HIV Care Coordination service.

Part 4 – PROGRESS MONITORING

Implementation Plans
The major service component discussed in this plan, the HIV Medical Service Program, has been in continual operation for several years. The implementation of any changes to this or any other program discussed herein will occur accordingly to the timeframes identified in the Service Delivery Plan (Part 3 of this document).

Monitoring Plans
The Division intends to continue monitoring its Title II contracts through the use of site visits, programmatic audits, utilization analysis, and monthly claim reviews. State-funded contracts (specifically for HIV Care Coordination) are also monitored through site visits, programmatic audits, and claim reviews; further, quarterly service provision is analyzed to determine compliance with quantitative guidelines. Title III projects will continue to conduct regular internal utilization reviews and to submit the required reports.

Evaluation Plans
The goals and objectives described in this plan will be reviewed regularly by the state's Comprehensive HIV Services Planning and Advisory Council which meets on a bi-monthly basis. Subcommittees may be assigned to devote particular attention to applicable sections of the plan. Objectives not achieved within the specified timeframe will be considered for continued relevance. Resources will be refocused as needed to address any outstanding issues, and timeframes will be adjusted accordingly.

CONCLUSION

Indiana's Statewide Comprehensive Plan for FY2006-2007 provides a thorough description of the service delivery system for HIV care funded through Title II of the Ryan White CARE Act and through allocations from the state of Indiana. It highlights the collaborations that the Division of HIV/STD has established with other HIV-related programs in the state to maintain a cohesive continuum of care. By incorporating the Statewide Coordinated Statement of Need, it also provides a description of the needs of persons living with HIV in the state and summarizes the perceived barriers to meeting those needs. The plan recommends a number of actions designed to overcome the identified barriers and summarizes the goals and objectives intended to address each priority service need.

Limitations

Due to the limitations of the funding and of the current health care delivery system in Indiana, some of the identified needs (such as dental and transportation services) are exhaustively addressed in this Statewide Comprehensive Plan. The Division expects to continue its efforts to develop partnerships with other CARE Act grantees and other providers to ultimately reduce the impact of these needs on the HIV+ population in the state.

The Statement of Need portion of the plan relies heavily on the state's HIV/AIDS Needs Assessment Report, which was finalized and presented to the Division in February 2002. This report attempted to quantify needs based on direct feedback from consumers and providers of HIV-related services. Because of the subjective nature of the self-reported data from consumers, some areas of need may be under- or over-represented. Also, much of the information contained in the report was collected in 2000 and 2001 during a time of great transition for HIV services in Indiana, and many providers failed to respond. The report was not finalized until 2002. The report's information, and thus the needs identified, must be considered in this context.

Future Plans

The document is intended to be updated each year as the Division's response to the epidemic improves and expands. During the revision process, the Division will encourage increased involvement from consumer and members of the Comprehensive HIV Services and Advisory Council. The plan and its goals and objectives are scheduled for a complete revision for FY 2009-2010.